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HOSPITALS

JOURNAL OF THE
AMERICAN
HOSPITAL
ASSOCIATION

MAY 16, 1960

A HOSPITAL SURVIVES 1000 DEGREES

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HAUSTED *Easy Lift* WHEEL STRETCHERS

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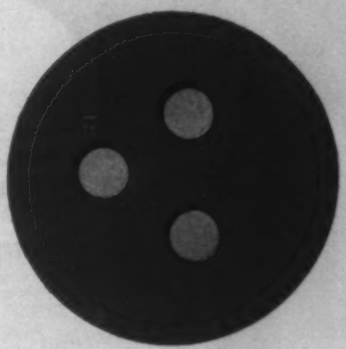

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Published by the American Hospital Association; Edwin L. Crosby, M.D., executive vice president and director

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cover

A blazing ball park across the street from Baptist Memorial Hospital, Memphis, Tenn., sent outside temperatures of the facing walls of the hospital to as high as 1000°F. How patients and personnel—and the hospital itself—reacted to this emergency is the subject of a special report beginning on page 17. Cover photograph courtesy of the Memphis *Commercial Appeal* (Robert Williams). (Other picture credits p. 132.)

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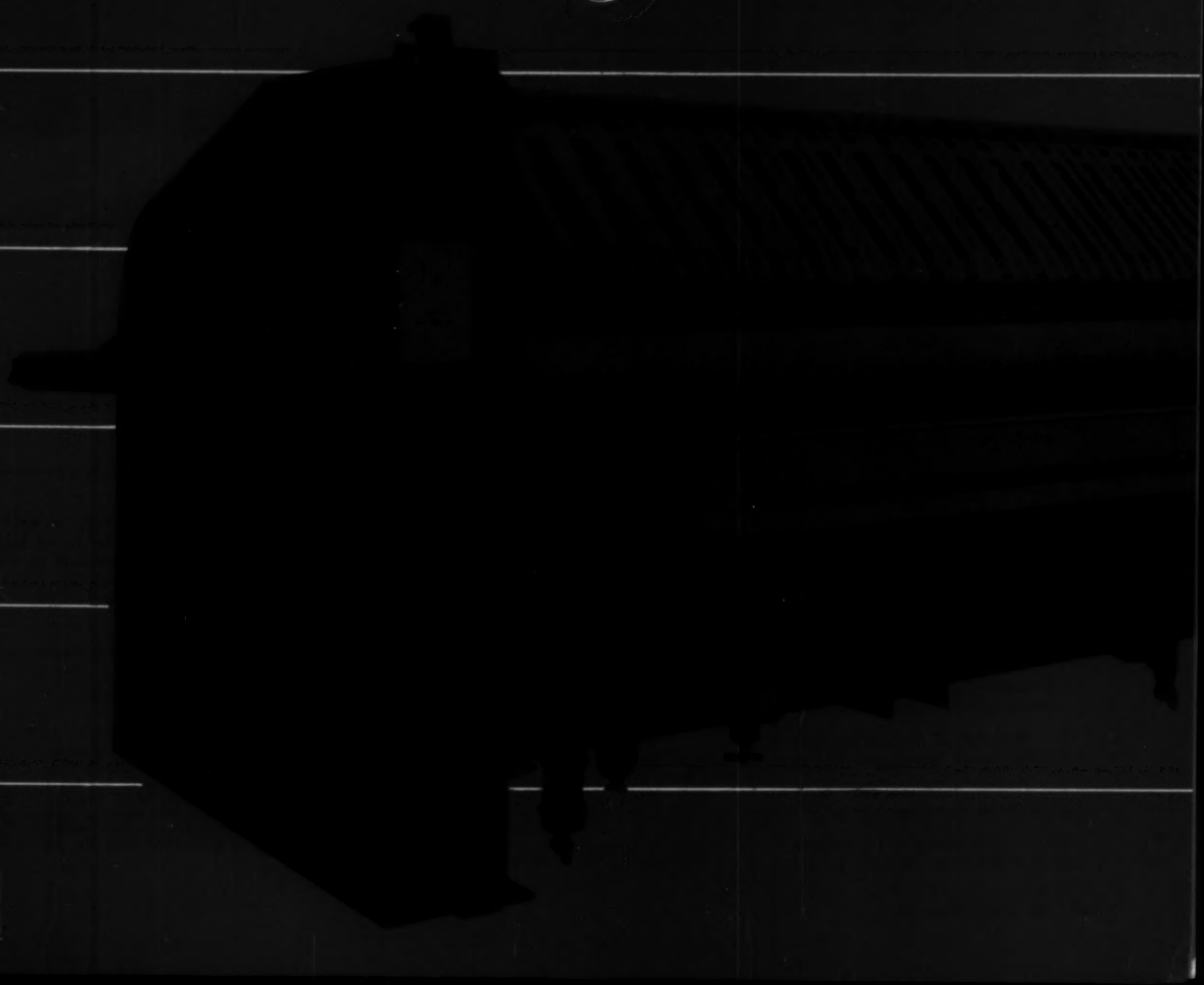

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2

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Type 3EF-BA. Automatically folds bib aprons in three 40″-wide lanes directly from any 120″ Ironer. A manual selector instantly combines the three lanes into a single 120″-wide lane for folding large pieces.

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Type 4EF. Four lanes, two lanes or one lane as you need them. The four 30″-wide lanes operate independently, boost production by eliminating stagger-feeding. A manual control also sets Folder for operation of two 60″-wide lanes or one 120″-wide lane.

7

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8

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9

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hospital association meetings

AMERICAN HOSPITAL ASSOCIATION

NATIONAL MEETINGS

1960

Aug. 29-Sept. 1—**62nd annual meeting,** San Francisco (Civic Auditorium and Jack Tar Hotel)

MEETING AND INSTITUTE

CALENDAR

THROUGH OCTOBER 1960

(American Hospital Association Institutes are in BOLDFACE type. Meetings of other hospital associations are in LIGHTFACE type. ***Other organizations in the health field are shown in ITALICS.)***

MAY

16-18 ***American National Red Cross,*** Kansas City
16-18 **Hospital Law,** Washington, D.C. (Willard Hotel)
16-18 **Patterns and Principles for Auxiliary Leaders,** Chicago (AHA Headquarters)
16-19 **Hospital Dental Service,** Atlanta (Henry Grady Hotel)
23-25 Canadian Hospital Association, Toronto (Park Plaza)
23-26 **Evening & Night Nursing Service Administration,** Seattle (New Washington Hotel)
23-27 **Dietary Department Administration,** Washington, D.C. (Willard Hotel)
26-27 Tennessee Hospital Association, Memphis (Peabody Hotel)
30-June 2 Catholic Hospital Association, Milwaukee (Auditorium)

JUNE

6-10 **Food Purchasing,** Chicago (AHA Headquarters)
7-8 Maine Hospital Association, Rockland (Samoset Hotel)
8 Connecticut Hospital Association, Berlin (Connecticut Light and Power Co.)
6-8 North Carolina Hospital Association, Morehead City (Morehead Biltmore Hotel)
11-16 ***American Society of X-Ray Technicians,*** Cincinnati (Netherland Hilton Hotel)
13-15 **Personnel Administration (Advanced),** Chicago (AHA Headquarters)
13-17 ***American Medical Association,*** Miami Beach (Miami Beach Hall)
19-21 Michigan Hospital Association, Traverse City (Park Place Hotel)
19-24 ***American Society of Medical Technologists,*** Atlantic City (Hotel Ambassador)
20-22 Mississippi Hospital Association, Biloxi (Buena Vista Hotel)
20-24 **Hospital Pharmacy (Basic),** Columbus (Ohio State University)
20-24 **Dietary Department Administration,** San Francisco (Whitcomb Hotel)
26-July 2 ***American Physical Therapy Association,*** Pittsburgh (Penn-Sheraton Hotel)
27-29 Comite des Hopitaux du Quebec, Quebec City (Provincial Exhibition Grounds)
29-July 1 **Nursing Home Administration,** Chicago (AHA Headquarters)

JULY

11-13 **Methods Improvement,** Omaha (Sheraton-Fontenelle Hotel)
18-22 **Hospital Engineering,** Los Angeles (Biltmore Hotel)

AUGUST

1-2 **Safety and Insurance,** Denver (Cosmopolitan Hotel)
1-5 **Hospital Pharmacy (Basic),** Minneapolis (University of Minnesota)
8-10 **Hospital Administration,** Oklahoma City (Oklahoma Biltmore Hotel)
14-19 ***American Society of Hospital Pharmacists,*** Washington, D.C. (Shoreham and Sheraton-Park Hotels)
14-19 ***American Pharmaceutical Association,*** Washington, D.C. (Shoreham and Sheraton-Park Hotels)
15-19 ***National Association of Boards of Pharmacy,*** Washington, D.C. (Shoreham and Sheraton-Park Hotels)
21-26 ***American Association of Blood Banks,*** San Francisco (Jack Tar Hotel)
21-27 ***American Association for Hospital Planning,*** San Francisco

(Continued on page 123)

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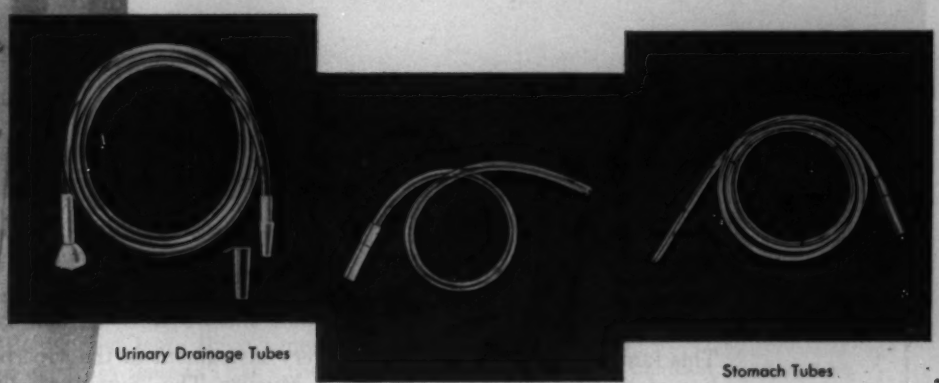

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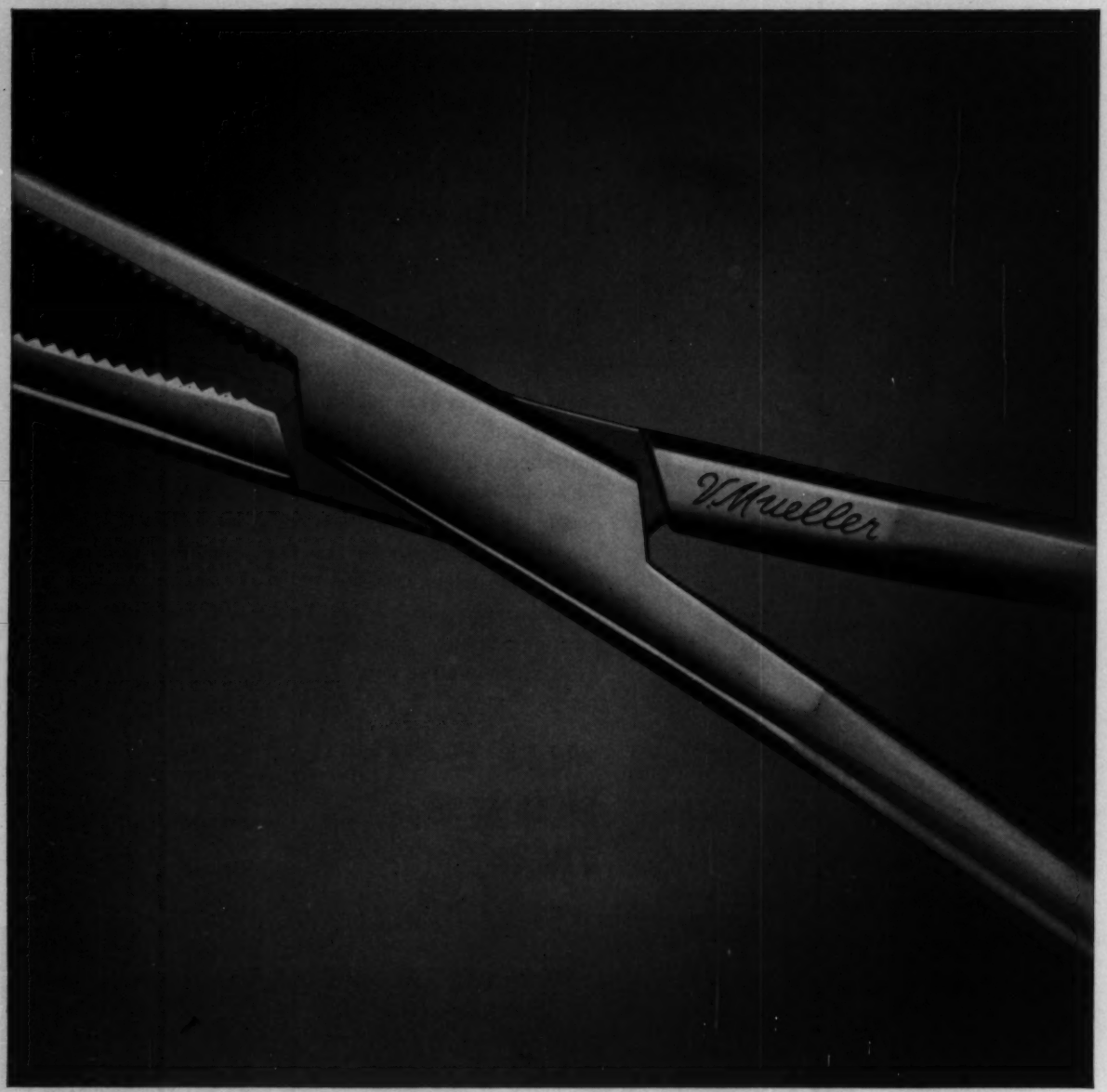

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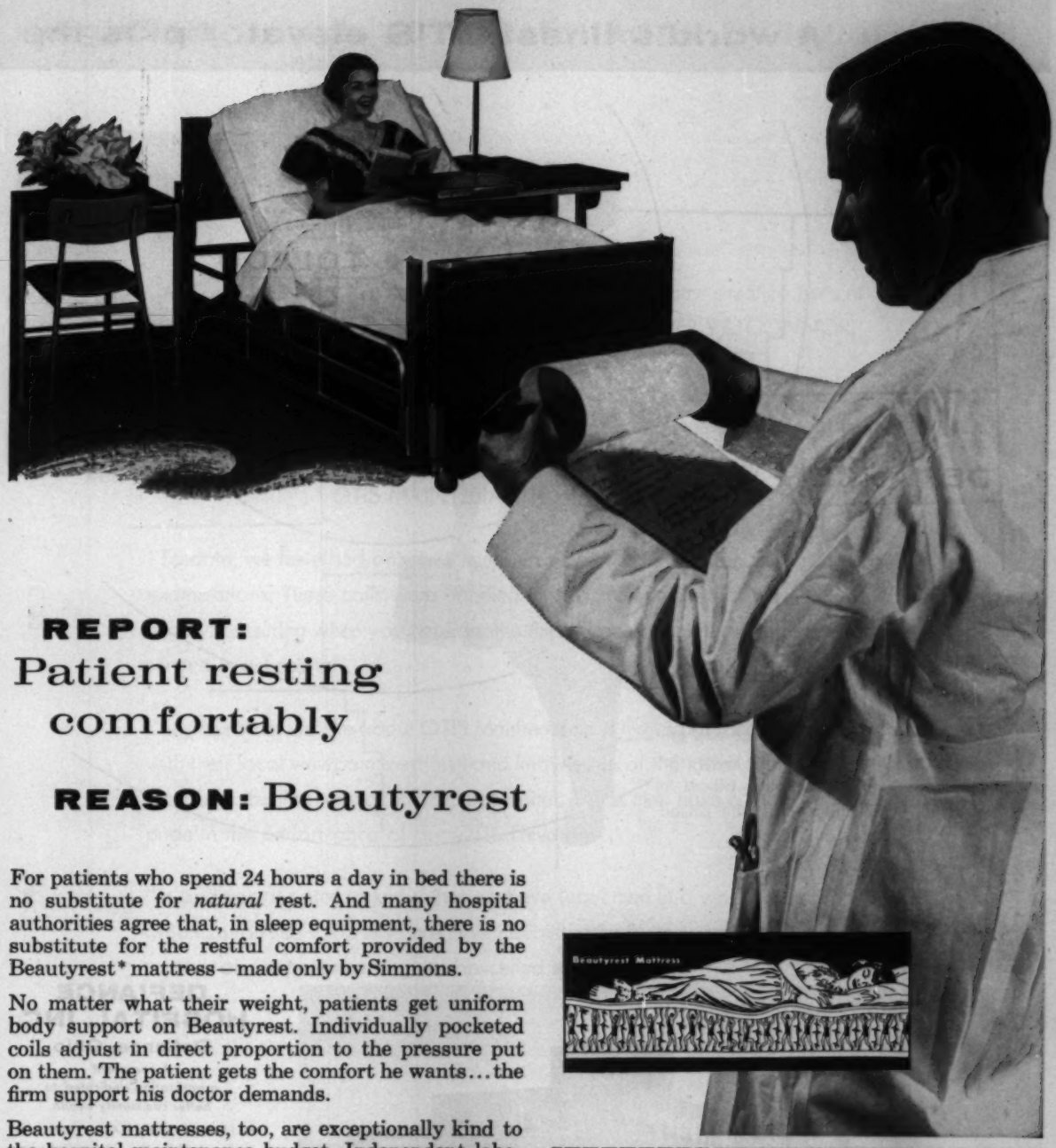

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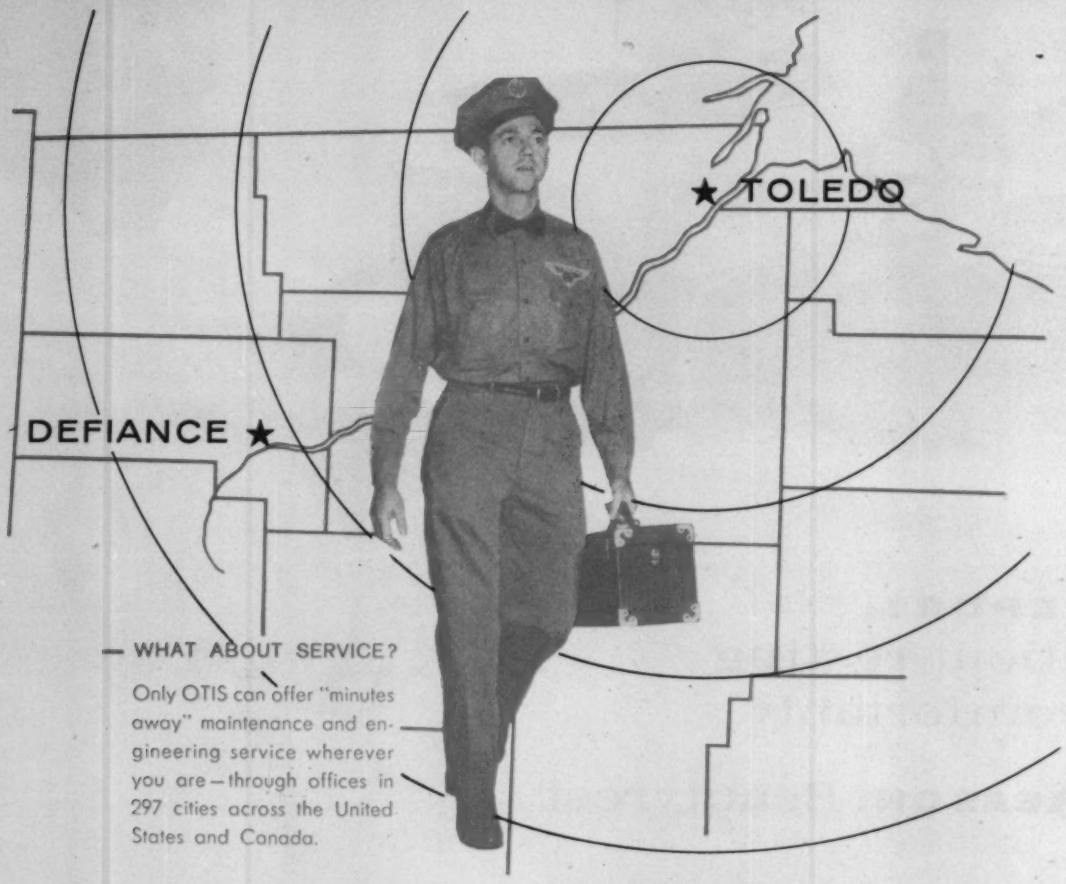

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Administrator

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introducing the authors

Mrs. Anne Gross, director of volunteer services at Mount Zion Hospital and Medical Center, San Francisco, describes some of the problems encountered by the hospital volunteer due to the fact that she is supervised by three "heads" within the hospital organization (p. 48).

MRS. GROSS

Prior to joining the Center's staff in 1956, Mrs. Gross was engaged in public relations and fund-raising activities for the New York firm of Holland Estill Associates. She also has been associated with the Muscular Dystrophy Association of San Francisco, the American Association for the United Nations (San Francisco), the United Bay Area Crusade and with the Community Chest of San Francisco.

Last month Mrs. Gross served as secretary of the section for directors of volunteer services in hospitals during the annual meeting of the Association of Western Hospitals. Mrs. Gross is a past chairman of the Association of Hospital Volunteer Directors, Northern California.

She is a graduate of Sarah Lawrence College, Bronxville, N.Y. Mrs. Gross has completed several courses towards her master's degree in psychology at Columbia University.

Mrs. Helen K. Johnson explains why the executive housekeeper should be a member of the planning committee for new hospital facilities (p. 101).

MRS. JOHNSON

Mrs. Johnson joined the staff of The Menninger Foundation in Topeka Kans., as executive housekeeper in 1946.

Mrs. Johnson currently serves as a member of the Committee on Housekeeping in Hospitals, American Hospital Association Council on Administrative Practice.

A member of the National Executive Housekeepers Association, Mrs. Johnson is graduate of the short course in hospital housekeeping of Michigan State University. She has completed courses in personnel management, advance supervisor orientation and work simplification offered through the University of Kansas extension program.

Mrs. Johnson attended the University of Kansas, Lawrence.

Glenn R. Stevens makes recommendations for developing good communications between the engineering and purchasing departments, particularly as they relate to specifications for equipment and supplies (p. 86).

MR. STEVENS

For the past seven years Mr. Stevens has served as director of engineering service for the Department of Medicine and Surgery-Operations, Veterans Administration, Washington, D.C. From 1950-53 he served as chief of the Maintenance and Operations Division of the VA Construction Service in Washington. Mr. Stevens brought to his Washington posts more than 15 years of experience as a hospital engineer and resident engineer for alterations and improvements at a number of VA hospitals. He has also served as director of construction, supply and real estate for the VA Branch Office No. 6 in Columbus, Ohio.

Mr. Stevens received his bachelor's degree in civil engineering from Union College, Schenectady, N.Y. A registered professional engineer in the District of Columbia, Mr. Stevens is a fellow of the American Society of Civil Engineers.

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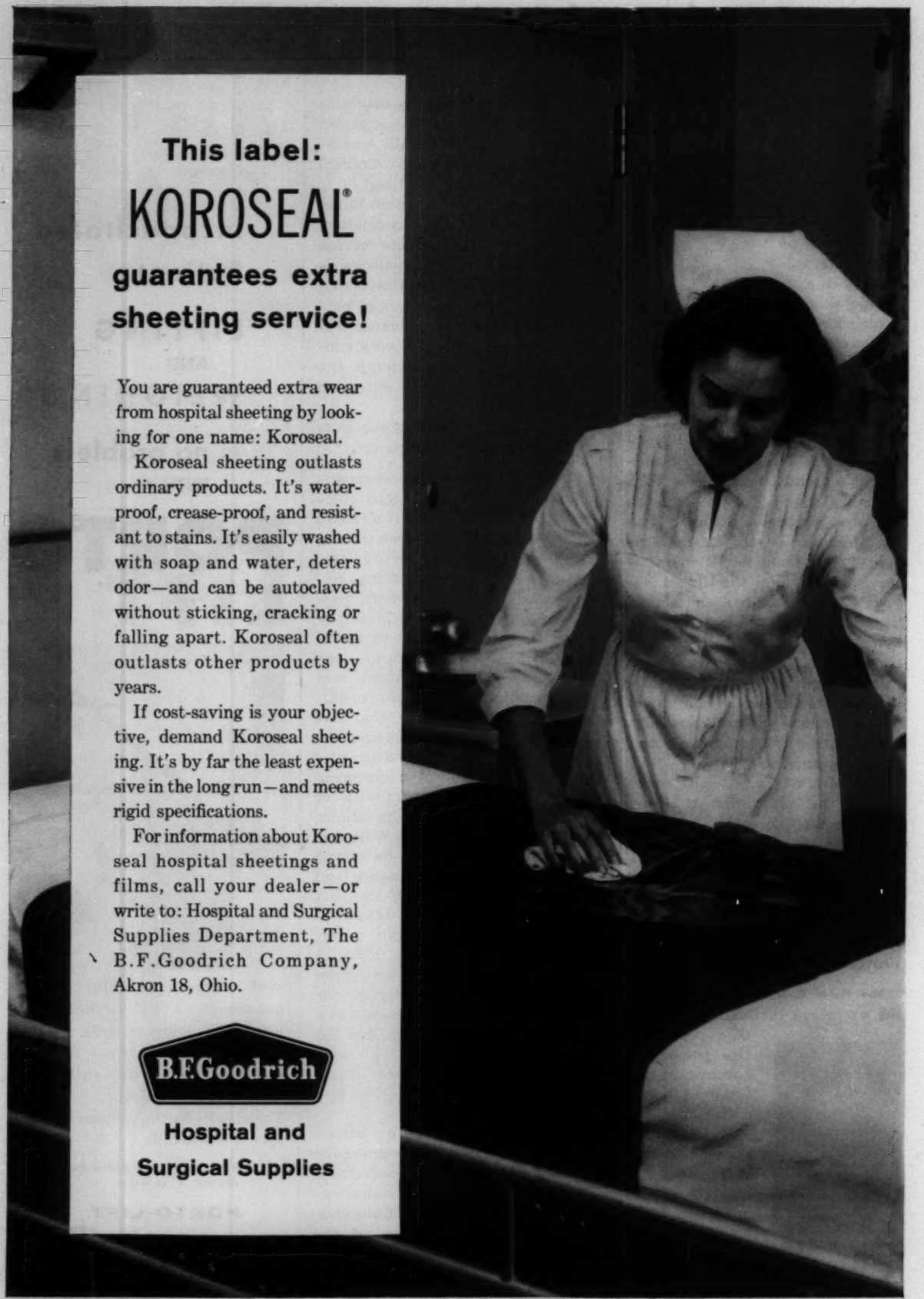

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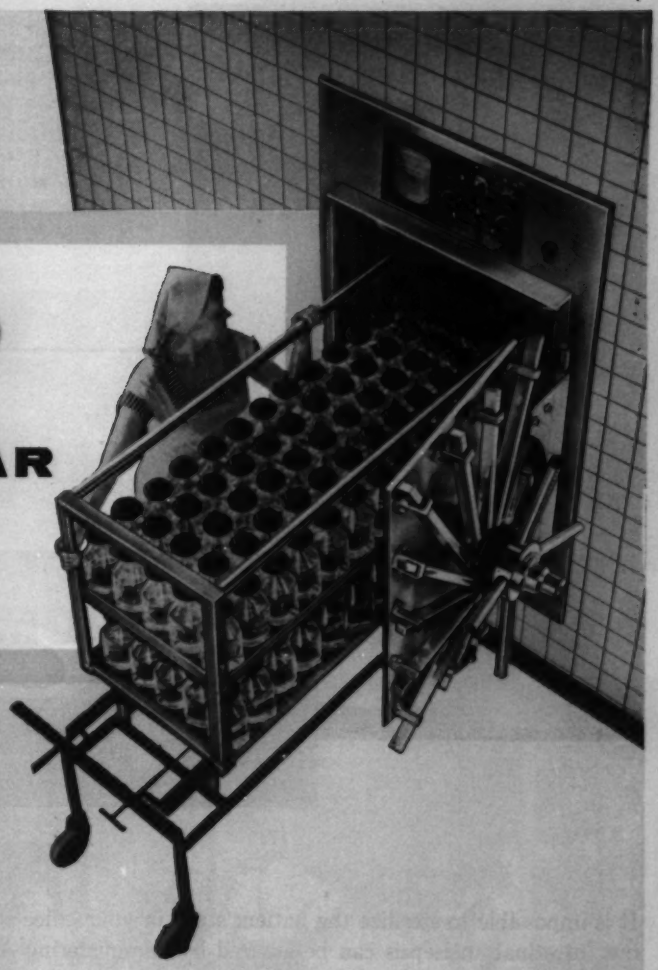

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- Solution exhaust valve speeds cooling of flasked fluids.
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But the truly exclusive feature of the American M. E. is the integrity of design and manufacture which is summed up in the phrase "made by American Sterilizer." Only from that priceless ingredient can you derive the ultimate in convenience, efficiency and lasting economy.

▼ *Write for Bulletin SC-305*

AMERICAN STERILIZER
ERIE • PENNSYLVANIA

Offices In 14 Principal Cities

Sterilizing the Gut

actol
SOLUTION

the synergistic intestinal bactericide

It is impossible to sterilize the patient's gut in your office sterilizer, but intestinal antisepsis can be assured by administering Actol before and after surgery.

In vitro tests show Neomycin Sulfate and Polymyxin B Sulfate in combination exert a synergistic action from 2 to 10 times as effective against susceptible organisms as either antibiotic alone.*

Actol is *bactericidal* to both gram-positive and gram-negative organisms specifically associated with intestinal infections*—

Escherichia coli • Aerobacter aerogenes • Pseudomonas aeruginosa • Staphylococci • Enterococci • Streptococci • Proteus vulgaris • Shigella paradysenteriae • Shigella dysenteriae • Salmonella species.

After oral ingestion, 3% of the total intake is the largest amount of Neomycin demonstrated in the urine. The bulk of Actol is excreted in the feces, permitting effective bactericidal concentration in the intestines.*

Since systemic absorption is insignificant, Actol will not induce sensitivity reactions when used as indicated.

FORMULA:

Each teaspoonful (5 cc.) contains:

Neomycin Sulfate U.S.P. (Equivalent to 45.5 mg. Neomycin Base)	65 mg.
Polymyxin B Sulfate U.S.P.	5,000 units

*References available on request.

THE S. E. MASSENGILL COMPANY
BRISTOL, TENNESSEE
NEW YORK • KANSAS CITY • SAN FRANCISCO

"BANDAGES"—strips of adhesive tape—were placed on all the cracked windows of the hospital to prevent their falling out until emergency crews replaced them.

THE 'TEST BY FIRE' OF BAPTIST MEMORIAL HOSPITAL

by FRANK S. GRONER

APPROXIMATELY 225 patients were evacuated from the threatened areas of Baptist Memorial Hospital. Most were taken to older sections of the hospital that were furthest from the fire.

A RAGING WIND-SWEPT fire on Sunday evening, April 17, destroyed Russwood baseball park in Memphis and threatened the lives of nearly 1500 hospital patients in two nearby hospitals that provide approximately 70 per cent of the city's general hospital beds.

A 20-mile wind out of the north threw flames and blazing embers against the side of the four-year-old Madison-East Unit of Baptist Memorial Hospital, directly across the street from the ball park. At John Gaston Hospital, which faces another side of the park, window frames caught fire but there was no interior blazing.

The fire started at 7:30 p.m. and raged until around 10 p.m., and was still smoldering some 18 hours later. Six buildings in the immediate area were completely destroyed.

Some 225 patients were moved from the threatened wing of Baptist Memorial Hospital and 68 babies were evacuated from the Gaston Hospital.

DISASTER PLAN EFFECTED

Baptist Memorial's disaster plan was thrown into effect immediately after the fire was reported. Approximately 600 employees were on duty at the time the fire broke out and 400 more were summoned to emergency duty. There had been two full-scale disaster drills and employees went immediately to their assigned stations. There was no panic among the patients. Police and the fire department had participated in the drills and were able to keep a large number of the curious out of the area. Nearly all of the 400 employees who reported for emergency duty were carrying disaster identification cards issued by the hospital.

Sailors in Memphis on liberty from a nearby naval air station were rounded up by shore patrolmen and placed on emergency duty as a cordon of guards around the area. University of Tennessee medical students responded to the hospital's call and remained on duty all night.

Flames leaped 100 feet into the air and for 45 minutes the outside temperature of the walls of the Madison-East unit of Baptist Memorial facing the fire ranged from 400 degrees at the ground level to 1000 degrees on the 12th floor. Due to atmospheric conditions, the temperature varied greatly and was reduced.

All of the windows in the ground floor of the building broke from

Frank S. Groner is administrator of Baptist Memorial Hospital, Memphis, Tenn., and president-elect of the American Hospital Association.

the heat and thick smoke billowed through the openings, penetrating to the fifth floor of the hospital. Although many patients experienced great discomfort from the smoke, there were no casualties. There was extensive heat, smoke and water damage on the first floor where the lobby, business office, public restaurant, and administrative offices are located.

ALL WINDOWS CRACKED

Windows in all floors above ground level of the Madison-East unit are of the double pane type. Outer panes in all 651 windows and inner panes in 32 were cracked but none gave way. Firemen, expecting the windows to break, instructed hospital personnel to pull down all curtains in rooms facing the fire and to remove all other flammable material from the rooms into the corridor. The intensity of the heat is illustrated by the fact that some employees who attempted to pull down the curtains with bare hands suffered blisters.

Evacuation of the 225 patients was accomplished in approximately 15 minutes. Since completion of the Madison-East unit, the hospital has been in the process of remodeling the older building, 100 beds at a time. Many patients were transferred into this area. Approximately 100 were transferred to a "disaster" area, which is composed of classrooms constructed in such a way that they can be used to house patients in emergency situations.

Three other local hospitals not in the immediate vicinity each set aside sections for emergency cases and each called in extra personnel to staff these beds if they were needed.

Critically ill patients (approximately 20) were assigned to the intensive care unit, and 20 others to the recovery unit. Many of the ambulatory patients were escorted to the employees' cafeteria, where food was served.

AN ADDITIONAL PROBLEM

The fact that there are several hospitals in the medical center complex presented what could have been an additional problem: caring for emergency cases in addition to evacuating our own patients. Medical staff members of the disaster team were punctual in answering calls, and a first aid station was set up for others in the disaster area. Although the hospital handled eight or ten emergencies during the fire, only two were fire victims.

Close liaison was maintained with the fire and police departments. Firemen remained at the hospital throughout the night and the following day. They were served breakfast, lunch and snacks by the hospital dietary department.

Hospital department heads had been thoroughly schooled in disaster procedure and each had involved key personnel from his department. This enabled us to have impromptu department head meetings two or three times during the night and early morning. These were brief but did serve as an aid in coordination.

Immediately following word from the city's mayor that the fire was under control, plans were made to return some of the patients to their rooms. Emergency crews working throughout the night had approximately half of the rooms ready for occupancy by daylight. The remaining rooms were made ready for occupancy during the day. Within 24 hours after the outbreak of the fire, all patients who had not been discharged were in their rooms. During the day the hospital admitted its usual Monday "load" of 145 patients. Many of the rooms had torn curtains and temporary window coverings and some windows were uncovered, but patients took these conditions in stride.

REPAIR WORK BEGINS

Crews began work immediately rehabilitating the first floor. Five glass companies were called and began work about midnight. All windows had been replaced by 7 a.m. The business office began its normal functions on time. Carpeted areas of the first floor were soaked with water, but were restored to normalcy within 24 hours.

In a "post-mortem" of this emergency we attempted to learn the weak spots in the hospital's disaster program. The following deficiencies were noted:

1. The hospital recently ordered identification bands to be used on all patients but the system was not yet in effect at the time of the fire. These identification bands would have been of considerable help.

2. We failed to anticipate problems which can be created by the curious, the vandals, and the pilferers—many of whom were able to break through the fire department and police cordon. As a re-

THIS close-up of some of the cracked windows was taken early the morning after the fire. Bright aluminum window frames were not affected by the heat, but colored aluminum spandrels warped.

ALL DRAPERIES were pulled down from rooms overlooking the ball park. Here hospital employees sort and inspect the drapes for damage.

sult, valuable personnel had to be stationed at the entrances to the hospital.

3. Failure on the part of the administration to instruct telephone operators in the "right answers" to give the hundreds of curious who called resulted in many short-lived but dangerous rumors and misunderstandings.

EMERGENCY CODE NEEDED

4. Although many of our key personnel were summoned by telephone according to plan, others heard of the fire by radio or television, and although the first broadcasts mentioned only a "five-bell alert", many rushed to the hospital "just in case". If we had had some code for summoning our personnel that could have been used by the radio and television stations, many more would have arrived at the hospital sooner.

5. With all of the glass out on the ground floor and heavy smoke inside the hospital for hours, heating presented a serious problem. Because we draw liberally on outside air for heating and air conditioning, it was necessary to cut off the heat on a rather chilly evening.

6. Electric power was cut off in several sections in the vicinity of the fire. One of the hospital's two sources of power was off for approximately five minutes. Although only one source was cut off, both sources of power for the hospital come from the same area. We realize now that for maximum safety, these power sources should enter the hospital complex from opposite directions. Although the hospital has all the recommended stand-by power and facilities, these are the minimum a hospital should maintain.

7. We were fortunate that our public address system continued functioning and we were able to communicate with all floors. It now seems that a stand-by system connecting nursing stations and other service areas would have been an added protection.

STRENGTHS DEMONSTRATED

Although an emergency such as this one shows weaknesses in a hospital's preparedness for disaster, strengths are also demonstrated and judgments vindicated.

Newspaper pictures the day after the fire showed city blocks in ruins. The damage comes to an abrupt halt at Baptist Memorial Hospital on the south and John Gaston Hospital on the west. This, I think, is a tribute to the way hospitals are built. The morning after the fire, the chief of the fire department said, "I know of no other building which has ever withstood the punishment yours had without being a total loss. It is amazing that Baptist Hospital still stands and it is a miracle that there was virtually no interruption of services." Had not double-pane windows been used in the upper floors of the hospital, damage to the hospital and danger for patients would have been many times greater.

About three years ago the hospital acquired a 10-story apartment building a block and a half away, partly as a means of having personnel near at hand in case of emergency. Priority in the renting of apartments is given to employees of Baptist Memorial Hospital and other hospitals in the medical center complex. When the fire broke out, around 50 employees living in the building were on the scene in a matter of three or four minutes.

FINE PERFORMANCES

Personnel of Baptist Memorial Hospital turned in fine performances in the emergency. Their calmness in carrying out procedures established in the disaster plan gave confidence to the patients. When circumstances did not seem to lend themselves to the plan as set down, personnel were able to exercise good judgment. For example, we had planned that patients dependent upon oxygen would be carried to certain locations. But as fire precaution, the hospital's central oxygen system was shut off. Inhalation therapy department personnel, sensing the danger and realizing that one section of the hospital was in little danger, quickly set up oxygen equipment on alternate floors in this section. Critically ill patients requiring oxygen were swiftly transferred to these areas with virtually no break in administration. We feel sure that three lives were saved through this action.

Baptist Memorial Hospital follows a policy of periodic re-evaluation of property insurance protection. In an estimate made (by a group of insurance companies) just 60 days before the fire, total value of the property for insurance purposes had been increased by approximately three million dollars. New policies had been placed in effect. This factor, which afforded 100 per cent protection from fire, probably saved the hospital around $40,000 in this estimated $250,000 loss. ■

68 NEWBORN EVACUATED FROM SECOND THREATENED HOSPITAL

John Gaston Hospital, located just a few feet across an alley west of Russwood Park, for a time seemed in greater danger than Baptist Memorial Hospital. But stiff southerly winds kept the flames blowing away from the building most of the time.

The hospital's disaster plan went into prompt action to smooth the way for evacuation of patients to areas previously determined for emergency use. Medical students and physicians fought the fire with wall fire hoses from second and third floor windows while behind them nurses took mothers and newborn babies to safety. Intense heat blistered paint and cracked windows on all four floors of the hospital's maternity division.

With 68 babies and 24 mothers evacuated from the threatened rooms, hospital personnel tore flammable blinds from the windows. All moveable medical equipment, records and utensils were moved from fire-threatened rooms into hallways.

Evacuation of the babies was completed without injury. Twenty-one of the babies were premature and none was more than three days old. All of the babies wore identification bands. A human chain of physicians, nurses, medical students and volunteers moved the infants into temporary quarters in the nearby Frank T. Tobey Children's Hospital. None of the mothers was evacuated from the building, but those who had rooms on the side of the hospital nearest the fire were helped to another part of the building until the danger was over.

Robert C. Hardy, administrator, said fire damage was confined to broken and charred windows and window sills along one wall of the maternity division. He said the hospital's biggest problem was to clean up the water and broken glass from the rooms. He said that two other Memphis hospitals had offered help in relocation of patients. ■

Administration Proposes 'Medicare' for Aged

The administration's long-awaited health program for the aged was announced May 4.

Sidestepping the social security system, the plan proposes instead federal and state support for private organizations to provide the eligible aged with 180 days of hospital care and year-round nursing home or home care. It would also provide private duty nursing care, physician and dental services, surgical procedures, and up to $350 for prescribed drugs.

Termed "Medicare" for the aged by Arthur S. Flemming, Secretary of Health, Education, and Welfare, who presented the plan to the House Ways and Means Committee, the $1.2 billion a year federal proposal authorizes federal matching grants to the 50 states in establishing major medical coverage for elderly persons 65-years old or older with limited resources, whether or not they are eligible for social security. Enrollment would be voluntary.

Except for public assistance recipients, who would have the full cost paid for them out of public funds, the eligible elderly would pay an annual $24 enrollment fee, the initial $250 of the illness expenses, and 20 per cent of the remaining cost.

Initial reaction of House Ways and Means Committee members was varied. Rep. Burr P. Harrison (D-Va.) termed the proposed program "more socialistic and more unsound and ultimately more expensive than the Forand bill."

Rep. Bruce Alger (R-Tex.), on the other hand, said that the bill avoids objectionable Forand bill features "such as compulsion, impairment of incentive for private endeavors, and failure to provide protection to the individuals most in need of help." Rep. Thomas B. Curtis (R-Mo.) said he believed the plan would ease "the inefficient use of our hospitals."

In the Senate, Patrick V. McNamara (D-Mich.), chairman of the Senate Subcommittee on Problems of the Aged and Aging, declared that the "income limitations for eligibility, $2500 for an individual and $3800 for a couple, could exclude millions of elderly citizens who have just as great a need for health care at a minimum cost."

Democratic leaders in Congress did not immediately say whether they would abandon the social security system for a plan of this type. Senate majority leader Lyndon Johnson (D-Tex.) did say, however, that he expected "expeditious action" on some program by the Congress. *(See earlier story p. 111)*

- Two identical bills have been introduced—one in the House, the other in the Senate—to extend for another four years federal aid to practical nurse education and, in addition, to remove certain restrictions and thus make federal funds available also for already established educational programs. A statement from Donald G. Harms, president of the Alabama Hospital Association, supporting this legislation was heard at House subcommittee hearings on the bill. An American Vocational Association representative also testified in favor of the measure. *(Details p. 111)*

- Legislation to raise the salaries of Veterans Administration hospital managers to $16,500 has been recommended by the House Veterans Affairs Committee. The bill would also fix the salaries of professional services directors at $16,250. *(Details p. 112)*

- The U.S. Department of Labor has interpreted the bill sponsored by Sen. John F. Kennedy (D-Mass.) to extend wage coverage as not affecting nonprofit or charitable organizations. The Kennedy bill was being redrafted this month to reduce it in scope. *(Details p. 112)*

PANEL DISCUSSES UTILIZATION IN NEW YORK CITY—The effects of length of stay in combination with admission rates and operating costs were discussed by one of the panelists participating in a discussion of hospital utilization before the members of the Greater New York Hospital Association. Charles G. Roswell, director of hospital services division of United Hospital Fund of New York, maintained that a reduction in the length of stay will not necessarily result in lower per-case cost, unless that reduction is accompanied by a rise in admissions and a reduction in operating expenses.

Another speaker, representing the public, discussed factors contributing to the misunderstanding of hospitals and recommended measures to mitigate the public's critical attitude. *(Details p. 114)*

MAINTAINING HIGH CARE STANDARDS STRESSED AT OHIO MEETING—The opinions of many speakers participating in the Ohio Hospital Association annual meeting last month were summed up in the statement, "Let us not lose our nerve about rising costs and allow the quality of patient care to deteriorate." This statement was made by Ray E. Brown, superintendent of the University of Chicago Clinics, who was the opening speaker at the Columbus meeting. *(Details p. 114)*

DEGREE-GRANTING RIGHTS FOR HOSPITAL NURSING SCHOOLS SOUGHT—A proposal that hospital nursing schools be given the power to grant an associate degree in nursing has been submitted by the Hospital Association of New York State to that state's education department. Such a step would greatly increase the number of young women entering the nursing profession, the association argued. *(Details p. 117)*

Utterly unique..... the Dimensional Collection of patient room furniture designed by Donald Deskey for Shampaine. It radiates good cheer and is the nurse's best friend. Dimensional works well, too. Scientifically engineered adjustments respond swiftly to patient's needs. Plastic and painted metal surfaces need little care. Yours for the asking: a handsome brochure depicting special performance features, color choices and other pleasant details. Dimensional by **Shampaine** COMPANY

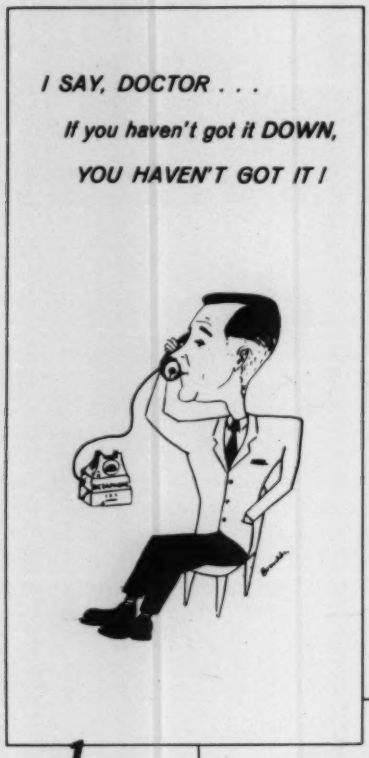
A DIVISION OF SHAMPAINE INDUSTRIES, INC./ 1920 SOUTH JEFFERSON, ST. LOUIS 4, MISSOURI

Program developed to promote use of dictating equipment

In designing the main building at Rhode Island Hospital, Providence, each patient floor was provided with a special area and facilities for telephone dictation of medical records. This equipment was installed to encourage completion of discharge summaries at the time of patient discharge. However, to achieve this objective, the physician needed to be reassured that use of this system was uncomplicated. He also needed to be reminded not to accumulate a large number of records for dictation at once.

To promote the use of a centralized dictating system, the chairman of the medical record committee proposed a publicity program using folders with cartoons to attract the attention of the medical staff. After careful planning and the assistance of a senior resident in surgery and the wife of a sur-

(Continued on page 27)



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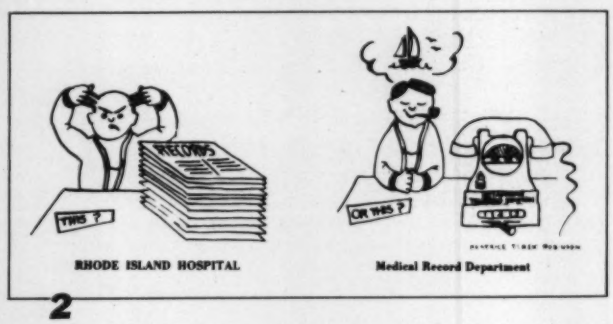

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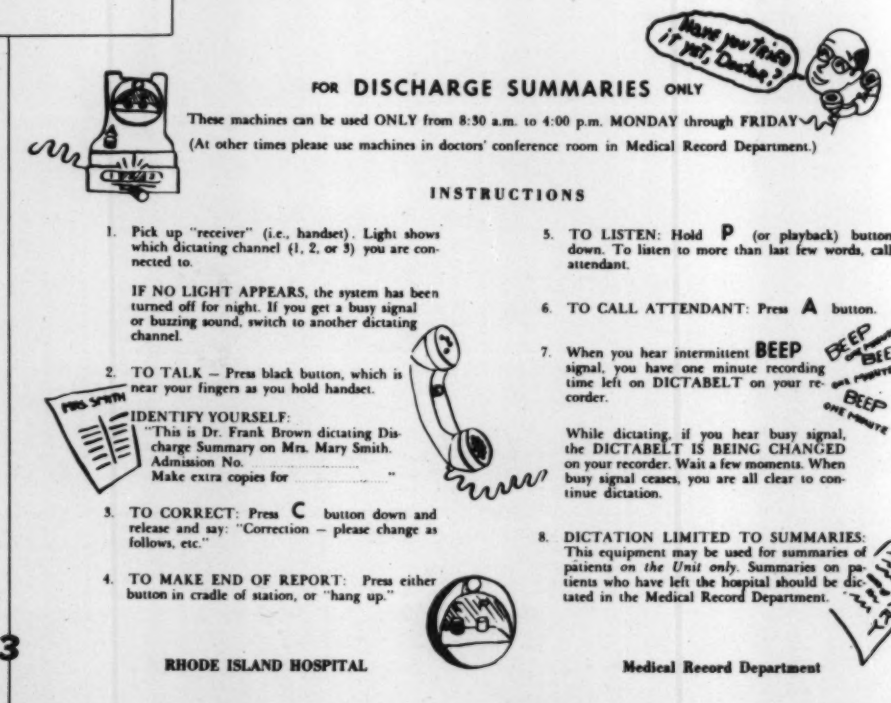

Have you finished it yet, Doctor?
FOR DISCHARGE SUMMARIES ONLY
These machines can be used ONLY from 8:30 a.m. to 4:00 p.m. MONDAY through FRIDAY
(At other times please use machines in doctors' conference room in Medical Record Department.)
INSTRUCTIONS
1. Pick up "receiver" (i.e., handset). Light shows which dictating channel (1, 2, or 3) you are connected to.
IF NO LIGHT APPEARS, the system has been turned off for night. If you get a busy signal or buzzing sound, switch to another dictating channel.
2. TO TALK – Press black button, which is near your fingers as you hold handset.
IDENTIFY YOURSELF:
"This is Dr. Frank Brown dictating Discharge Summary on Mrs. Mary Smith.
Admission No. .....
Make extra copies for ....."
3. TO CORRECT: Press C button down and release and say: "Correction – please change as follows, etc."
4. TO MAKE END OF REPORT: Press either button in cradle of station, or "hang up."
5. TO LISTEN: Hold P (or playback) button down. To listen to more than last few words, call attendant.
6. TO CALL ATTENDANT: Press A button.
7. When you hear intermittent BEEP signal, you have one minute recording time left on DICTABELT on your recorder.
BEEP one minute
BEEP one minute
BEEP one minute
While dictating, if you hear busy signal, the DICTABELT IS BEING CHANGED on your recorder. Wait a few moments. When busy signal ceases, you are all clear to continue dictation.
8. DICTATION LIMITED TO SUMMARIES: This equipment may be used for summaries of patients on the Unit only. Summaries on patients who have left the hospital should be dictated in the Medical Record Department.
RHODE ISLAND HOSPITAL
Medical Record Department

3

Just 75 years ago, heating was about as unpredictable as the weather, as temperatures alternated between shivery low and smother-high. Then a Wisconsin school-teacher named Johnson decided to do something about classroom comfort and thereby launched a new industry!

The Story of the Thermostat

Actually this is the story of a symbol . . . the symbol of an industry that has brought comfort, safety, better health, and efficient working conditions to people all over the world.

. . . In a hospital, surgeons perform a lifesaving operation. Accurate pneumatic controls maintain the temperature and humidity at pre-selected levels to conserve the patient's strength during surgery.

. . . In a specially equipped manufacturing plant, delicate missile parts and components, with micro-inch tolerances, must be made under temperature and humidity conditions that never vary. At every step in their manufacture, modern pneumatic controls assure error-free regulation of the thermal environment.

. . . Every morning of the school year, millions of students sit down to study and learn in comfortably heated and ventilated or even air-conditioned classrooms. To help provide this ideal environment, the great majority of schools and colleges everywhere depend on precision pneumatic control systems.

. . . Far at sea, one of the nation's deadly new submarines cruises undetected, an elusive, power-laden sentry of the "Silent Service." Her crew lives and works in comfort and safety — in a climate precisely regulated by a pneumatic control system.

. . . Across the continent, pneumatic controls assure safe air conditions in the highly critical processing areas of an atomic energy facility. Pneumatic controllers of extreme sensitivity operate constantly to assure safe disposal of waste air and prevent the escape of contamination.

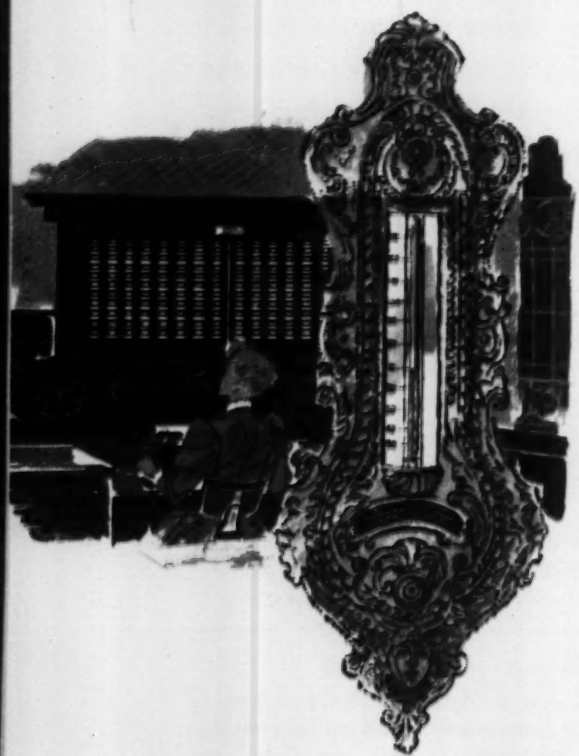
These are but a few examples of the ways in which modern pneumatic controls play a vital part in regulating the environment in which we live and work — helping to create made-to-order indoor climate for every purpose, controlling temperatures and humidities to a degree undreamed of when Professor Warren S. Johnson invented the first automatic temperature control system back in the 1880's.

Inventor at Work

Though he was probably unaware of the fact at the time, Professor Johnson became the founder of the automatic temperature control industry when he devised a practical way to eliminate the problem of classroom temperatures that seemed to zigzag forever between shiver and swelter.

His first attempt at control — the "annunciator" system — merely called the janitor's attention to overheating, or lack of heat, by ringing a bell in the furnace room. The janitor would then open or close the classroom dampers, as required.

But this land-based version of a ship's telegraph soon gave way to an all-electric method, utilizing a thermostat in each room that would open and close the dampers automatically. And so, the first system of automatic heat regulation was born.



The Electro-Pneumatic System

Intrigued with the possibilities of his long-awaited discoveries, Professor Johnson in 1883 left his post at Whitewater, Wisconsin, State College and came to Milwaukee to devote full time to refining and marketing the Johnson System.

His second major achievement, an electro-pneumatic control system, occurred almost at once. By successfully uniting the forces of *electricity*, for thermostat operation, and *compressed air*, for valve and damper operation, he developed a far more dependable and fully automatic control system. Finally he was ready to go out and revolutionize the comfort standards of the world. In 1885, he incorporated the business which today bears his name.

With branches established in Chicago, St. Louis, and New York, the Johnson thermostat on the wall soon became a familiar sight in the leading buildings of the day. Schools, prominent residences, and small business buildings were first to enjoy the comforts and economies of automatic control. They were followed closely by colleges, hospitals, public buildings, offices, stores, and industrial plants.

From Mikado to Czar

Acceptance grew, markets widened. The fame of automatic controls traveled fast and far. Before 1890, the city of Berlin, Prussia, had written a report about the efficiency of its Johnson System. Later, the palace of the Mikado in Japan was equipped with Johnson Control. The King of Spain and other European royalty became Johnson customers. A special installation was made in the Kremlin in Moscow!

Single Responsibility

Professor Johnson had the foresight to realize that the key to his success depended upon the *proper application* of his controls. Accordingly, he determined, from the outset, that his company should *never sell devices*, but should sell a *principle of control*. This meant that each system would have to be planned, manufactured, installed, and serviced *by Johnson* to meet the exact needs of the individual building.

Over the years, this policy of complete responsibility by a single specialized organization has insured owner satisfaction and saved untold millions of dollars for Johnson customers.

Carrying out this policy has also resulted in the closest possible working relationship between the Johnson organization and the nation's consulting engineers and architects, in a joint effort to provide ever better control of thermal conditions.

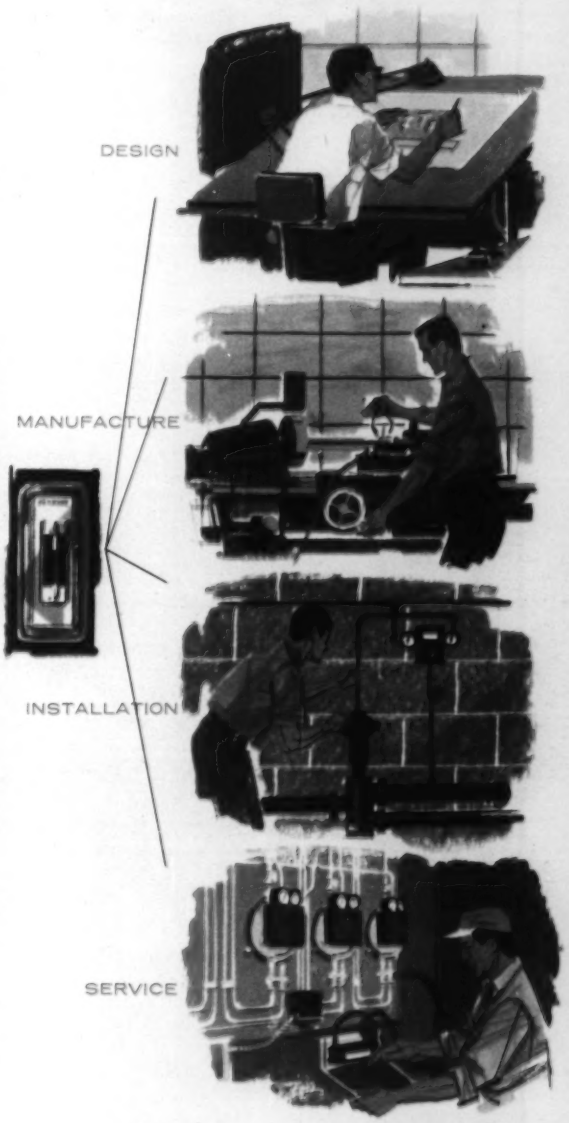
Many Johnson "Firsts"

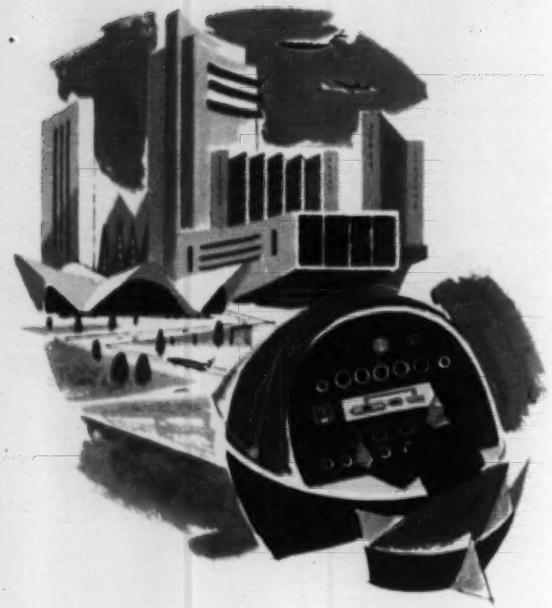
The history of the thermostat and the Johnson Service Company coincides with the period when other pioneers were busy introducing innovations in heating, cooling, and ventilating methods and in developing full-scale air conditioning. Working closely with the research staffs of these manufacturers, Johnson engineers were able to supply the most effective controls for every new development in basic equipment. This cooperation has continued and flourished to the present.

Over the years, the Johnson Service Company has been the source of a never-ending flow of new ideas, which have included virtually all of the key developments in the field of automatic temperature control!

By far the most important was the all-pneumatic control system, perfected in the 1890's and still the standard everywhere. Others include the all-metal thermostat, the famous *Dual* or day-night thermostat, the heating-cooling thermostat, summer-winter thermostats, the airstream thermostat, master-submaster thermostats, supersensitive gradual-acting thermostats, and powerful piston damper operators.

Another famous development was the Humidostat or humidity regulator. And, of course, the Comfostat, an exclusive Johnson instrument that controls room temperatures in relation to humidity conditions. The popular pneumatic control center, for centralized supervision and control of modern air-conditioning systems, also was first perfected by Johnson.





Uninterrupted Progress

As the concept of controlled environment gathered momentum, so did Johnson. Important "firsts" became routine jobs, as the industry looked to Johnson for the answers to new control problems. From the simple comfort needs of the buildings of the 80's and 90's, to the history-making demands of the first scientifically air-conditioned building, down to the most complex requirements of today's commercial and industrial buildings, Johnson has been the leader in the pneumatic temperature control field.

Today, no matter where you go, you'll find the important buildings are equipped with Johnson Control. From the fabulous Fontainebleau Hotel to the mammoth Merchandise Mart to the famous UN Secretariat Building . . . in schools, in sprawling defense plants, in research laboratories, in vital military installations, in shopping centers, in buildings of *every* size and type and in ships at sea . . . there are temperature and air-conditioning control systems by Johnson.

Johnson's work in the hospital field is especially noteworthy, for during the past 75 years Johnson has helped plan and has installed more hospital control systems than anyone else! In countless hospitals, Johnson Control is on 24-hour duty, helping to save lives, increase efficiency, and cut costs.

Johnson Today...and Tomorrow

To make certain that each installation performs up to expectations, Johnson backs its engineers with the most complete line of pneumatic temperature, humidity, and pressure control equipment in the industry.

To serve you most efficiently both before and *after* a sale, Johnson maintains the largest and most experienced field organization in the industry, with 107 completely staffed branch offices in the United States and Canada, plus full-time, factory-trained installation and service mechanics in over 200 other cities.

This is by no means the end of the story of the thermostat. For against this unmatched background of innovation, experience, and service, Johnson's never-ending search for new and better controls will inevitably lead to dramatic new ideas in the years ahead. As the day of completely air-conditioned cities approaches and as new and unprecedented demands for precision controls evolve, the forward-thinking Johnson organization will always be ready with the right answers.

The Johnson research and development staff and facilities have been expanded three times in the past four years. And final plans for the next major expansion are already underway! In the future then, as in the past, you can continue to look to Johnson for the world's finest controls!

Johnson Service Company, Milwaukee 1, Wisconsin. In Canada: Johnson Controls Ltd., Toronto 16, Ontario.

JOHNSON CONTROL

PNEUMATIC SYSTEMS

DESIGN • MANUFACTURE • INSTALLATION • SINCE 1885

AD 1075

Printed in U.S.A.

geon on the visiting staff in drawing the cartoons, the following program was put into effect at Rhode Island Hospital last September:

1. A letter was sent to members of the medical and house staffs describing the purpose of this campaign. The folder featured a cartoon on its cover and carried the caption, "I say, Doctor . . . If you haven't got it down, you haven't got it". The inside of the folder included a description of the telephone system for dictating medical records and why this system was installed (See illustration 1, p. 22).

2. A month later, the second cartoon was sent (see illustration 2, p. 22).

3. The third month a sheet of instructions, which included cartoon illustrations on the use of the telephone system, was sent (see illustration 3, p. 22). These instructions were similar to those placed by every telephone for dictation on the floors.

This three-month promotion was repeated again and will be repeated as need dictates. In addition, small cards stating, "It will save your time later to dictate your summaries now on telecord" are available in pad form at all nursing units. When a record is given to a physician by the receptionist, this reminder is attached to it.

Oliver G. Pratt, executive director of the hospital, reports that use of the telephone system has increased markedly since the inception of this promotion program. Each week new physicians are beginning to use this system. Also, priority is given in the medical record department to transcription of material dictated through this system. ■

Physicians' lectures help nurses improve patient care

Staffed by professional and practical nurses from different schools of nursing, St. Clare's Hospital, Schenectady, N.Y., was recently faced with the problem of refining and developing its techniques to improve the care of postoperative patients. To help solve the problem, a series of lectures for nurses was initiated by the hospital's anesthesiologist, Irvin Moss, M.D., to help standardize and improve the efficiency of nursing care in the postoperative recovery room.

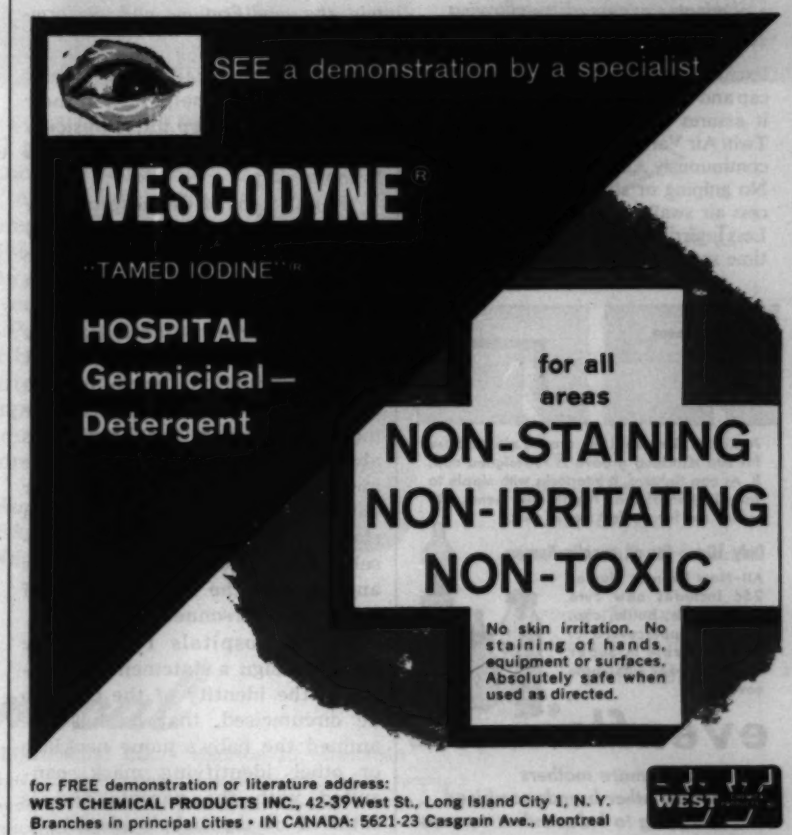
Sister Margaret Patricia, recovery room supervisor, welcomed Dr. Moss's suggestion and soon a series of lectures was being conducted for nurses during their off-duty time.

Sister M. Senana, S.F.P., the hospital administrator, reports that the response of the nurses to the postoperative care lectures was so enthusiastic that several of the staff physicians volunteered to give lectures covering their specialties for the nurses. Lectures are now given each week in the morning, afternoon or evening, depending on the physicians' schedules. John B. Phillips, M.D., chief of the hospital's obstetrical department, gives lectures on obstetrical emergencies. Joseph Cortesi, M.D., chief of the hospital's diabetic department, lectures to the nurses on the basic knowledge of and current management of diabetes. Gastric suction is the subject of the lectures given by Robert Breault, M.D.

Stephen C. Meigher, M.D., and the previously mentioned physicians also conduct a question and answer period following the viewing of films given for the nurses and the public once a month. Topics for the public have been "Self-Examination of the Breast," "What is Diabetes" and "Labor and Childbirth".

The main objective of these lectures is to refine and emphasize the role of the professional nurse as the leader responsible for the nursing assistants—the practical nurse and the nursing aide. The lectures are also designed to develop the technical skills of the practical nurse and nursing aide.

Sister M. Senana also reports that the lectures have pinpointed the need for a full-time inservice education program at the hospital. She reports that such a program is now in progress and a full-time clinical instructor has been appointed. However, the physicians' lectures will continue to serve as a valuable supplement to the newly-created inservice education program for nurses. ■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accreditation problems

KENNETH B. BABCOCK, M.D.

- ritual and religious circumcisions in the hospital
- ascertaining qualifications for mohels
- scrubbing for surgery
- sprinkler systems
- agreement between clinical and pathological diagnoses

Does the Joint Commission allow ritual or religious circumcisions by mohels or rabbis?

The answer is a qualified yes, because under no circumstances should there be a departure from good aseptic surgical techniques, rules and regulations. Each hospital, depending on its facilities, should have its surgical committee and the hospital administration write strict rules for conduct and techniques of the procedure.

Just because it is a religious ritual, the hospital cannot lower its standards and make exceptions. The hospital is still obligated by law to observe "due care".

* * *

If ritual circumcisions are performed, how can the hospital ascertain the qualifications and performance of the mohel?

Emanuel and Lillian Hayt and August H. Groeschel, M.D., in their book *Law of Hospital, Physician and Patient,* discuss this matter as follows:

"Regulations of the hospital may prescribe that the mohel comply with its aseptic technics, as the surgeon would when performing a minor operation, and that the patient's physician or a resident be present during the circumcision. It has been found desirable for the hospital not to suggest a particular mohel. Moreover, the hospital is absolved of the duty of 'due care and selection' when the father chooses the mohel and signs a statement that he is satisfied himself of the mohel's qualifications and releases the hospital, its staff and other personnel.

"Some hospitals require the mohel to sign a statement certifying to the identity of the child to be circumcised, that he has examined the baby's name necklace or other identifying mark, consulted with the parents and is satisfied of the baby's identity."

Should there be a difference in the length of time spent in scrubbing in surgery for a major or minor case, an E.E.N.T. case or an abdominal case?

No. Cleanliness is a matter of thorough scrubbing for a given length of time no matter what kind of case is to be handled.

* * *

It has been said that the Joint Commission requires a sprinkler system in all hospitals in their trash chutes, clothes chutes and storerooms. Is this correct?

No. It is not a JCAH requirement in all hospitals. It is a matter of judgment for the surveyor. The surveyor may recommend a sprinkler system in those areas in older nonfireproof buildings, while he may not recommend it in a newer building of more modern construction.

If there is any doubt, the hospital should obtain a written statement from its fire insurance representative and from the local fire marshal regarding the necessity of a system. The administrator should then show it to the JCAH surveyor when he visits the hospital.

* * *

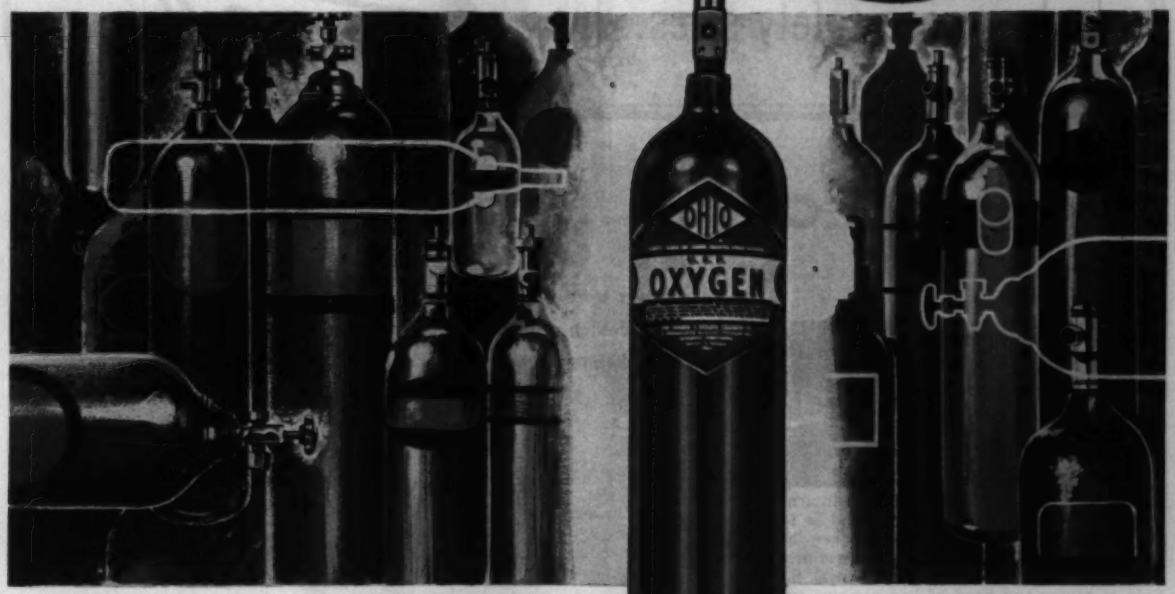
Our tissue committee contends that for a final diagnosis the clinical diagnosis must agree with the pathological one. Is this correct?

No. In usual hospital practice there is, on the average, disagreement in 15 to 20 per cent of the cases between the surgical diagnosis and the pathological diagnosis. This is especially true of operations for duodenal ulcers and for prolapse of the uterus. In the final review, the question is not one of diagnostic agreement but one of whether or not the procedure was acceptable.

This material has been prepared by the Joint Commission on Accreditation of Hospitals, Dr. Kenneth B. Babcock, director. Questions should be sent to the Commission, 200 E. Ohio St., Chicago 11, Ill., or to HOSPITALS, J.A.H.A., for referral to Dr. Babcock and his staff.

There is a difference

Here's an insect that looks so much like the foliage it frequents that only a sharp-eyed expert can spot it. It's called a Ceylonese walking leaf which is the tropical cousin to our own common Katydid. With this disguise, the walking leaf is safe from its many insect-eating enemies.



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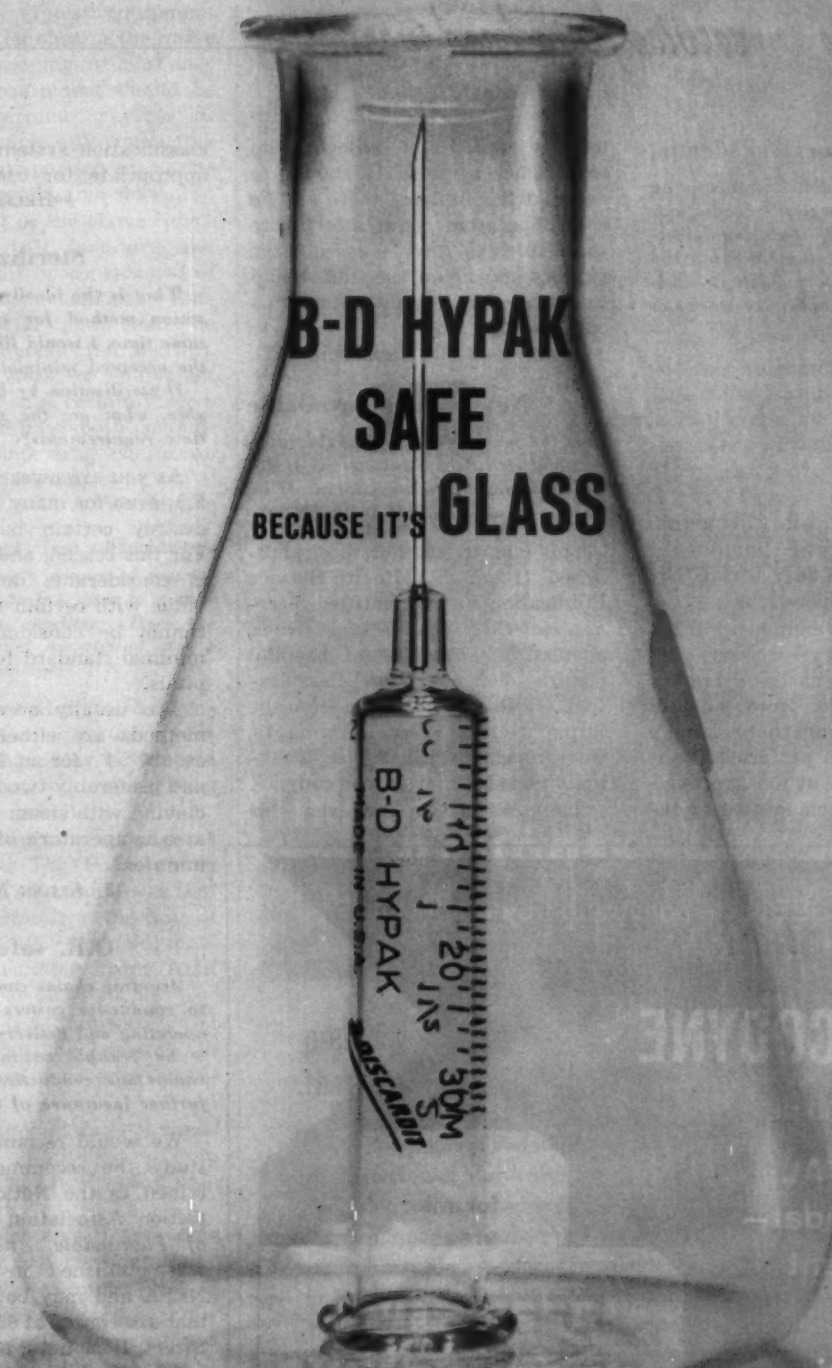

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'Surgical' deaths

In order to establish statistics on percentages of "surgical" deaths, our surgical committee would appreciate information concerning the time element in which such a death is established. Is it two weeks, six weeks or two months?

The Joint Commission on Accreditation of Hospitals, when surveying a hospital for accreditation, requests the following statistics with reference to "surgical" deaths:

Postoperative death rate within 10 days of surgery; i.e., number of deaths within 10 days divided by the number of operations.

Obviously, this cannot fulfill the complete category of "surgical" deaths inasmuch as there are instances of deaths from surgical conditions without there having been an operation performed. It is then the decision of the appropriate medical staff committee to determine the exact category to which such a mortality should be designated. Similarly there can be a postoperative death after more than 10 days have elapsed from surgery and, again, the staff should categorize the incident as to surgical, medical, etc.

—J. R. ANDERSON, M.D.

New manual available

Is the manual concerning the international statistical classification of diseases for hospital use available? If so, where can we obtain a copy?

This manual has now been published. It is Public Health Service Publication No. 719, entitled *International Classification of Diseases,* adapted for indexing of hospital records and operation classification. Copies are available from the Superintendent of Documents, Government Printing Office, Washington 25, D.C., at $1 per copy.

The Association believes this classification system is useful and appropriate for use in hospitals.

—HELEN D. MCGUIRE

Sterilizing syringes

What is the ideally accepted sterilization method for syringes? At the same time, I would like to know what the accepted minimal standard is.

If sterilization by boiling is acceptable, what are the temperature and time requirements?

As you are aware, boiling (212° F.), even for many hours, does not destroy certain bacterial spores. For this reason, and because there is considerable doubt as to its value with certain viruses, boiling cannot be considered as even a minimal standard for general hospitals.

The usually accepted standard methods are either by dry heat at 320° F. for at least one hour and preferably two hours, or autoclaving with steam under pressure at a temperature of 250°F. for 30 minutes.

—J. ALLAN MAHONEY, M.D.

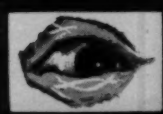
O.R. safety measures

Are drag chains considered superior to conductive casters for use in the operating and delivery rooms? Would it be feasible to install both drag chains and conductive casters to gain further insurance of safety?

We would recommend that you study the recommendations contained in the National Fire Protection Association *Code for Use of Flammable Anesthetics.* This was published in 1959 by the NFPA and may be obtained from that association at 60 Batterymarch Street, Boston 10, Mass. The price is 50 cents.

Drag chains are decreasing in popularity and use in hospital operating rooms in favor of conductive casters and rubber tips. One of the primary objections to drag chains is the fact that they become dirty and fail to act as conductors. This, of course, can

The answers to these questions should not be construed as being legal advice. Hospitals with legal problems are advised to consult their own attorneys.



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happen to any type of equipment and serves to emphasize the value of good housekeeping. At least once each month, equipment should be tested to determine whether or not it is completely conductive from the major portion of equipment to the conductive floor.

Section 3531 of the above reference states: "All furniture and equipment shall be constructed of metal or of other electrically conductive material and shall be equipped with conductive leg tips, conductive casters or equivalent devices." It would certainly seem unnecessary to have both conductive casters and drag chains on operating room equipment.

—G. A. WEIDEMIER

Pledge for volunteers

We are giving a course of instruction in nurse aide functions to women in our hospital auxiliary. Does the American Hospital Association have a pledge for volunteers?

The American Hospital Association does have a suggested volunteer pledge which may be adopted by hospitals for volunteers giving service to the hospital.

The pledge appears on page 93 of the manual *The Volunteer in the Hospital.* The manual was sent to member hospitals at the time of publication in 1959 but additional copies are available from AHA headquarters at $2.35 each.

The pledge is as follows:

Believing that the hospital has real need of my services as a volunteer worker:

I will be punctual and conscientious in the fulfillment of my duties and accept supervision graciously.

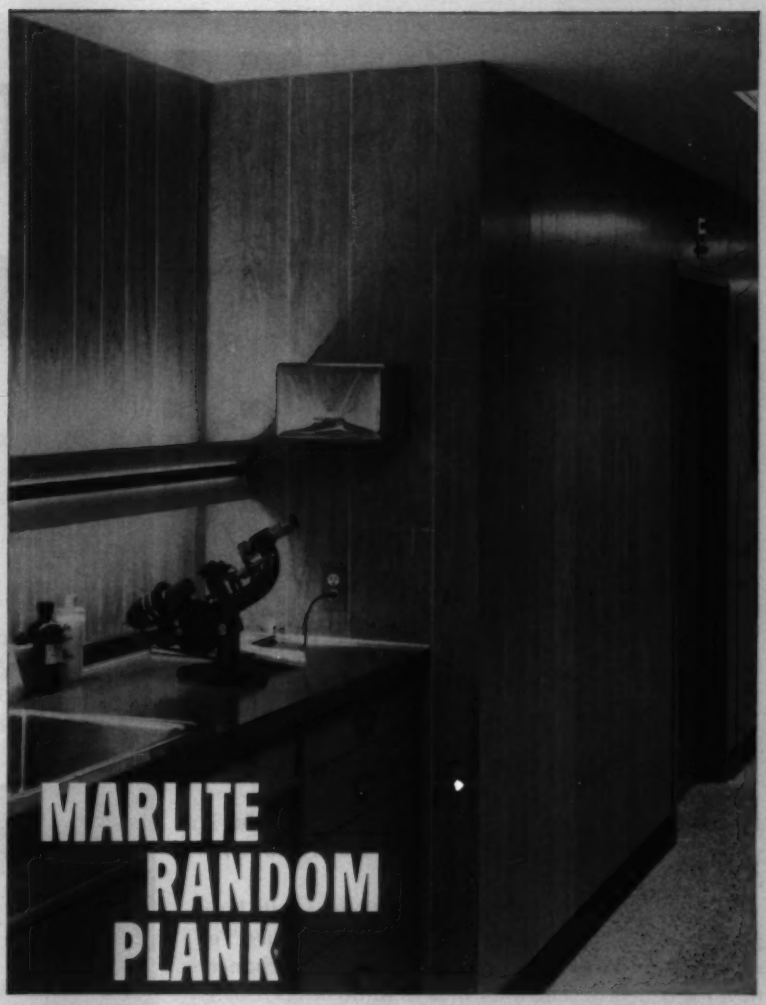
I will conduct myself with dignity, courtesy and consideration.

I will consider as confidential all information which I may hear directly or indirectly concerning a patient, doctor or any member of the personnel, and will not seek information in regard to a patient.

I will take any problems, criticisms or suggestions to the director of volunteers.

I will endeavor to make my work of the highest quality.

I will uphold the traditions and standards of this hospital, and will interpret them to the community at large.—GERMAINE FEBROW



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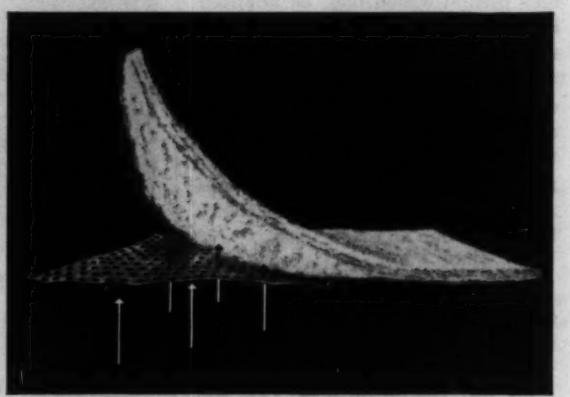

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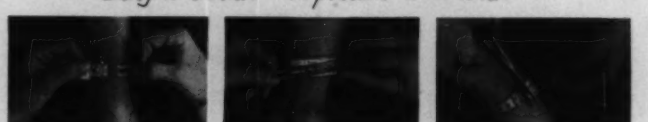

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staph newsletter

SIXTH OF A SERIES WITH SIGNIFICANT SUGGESTIONS FOR CONTROLLING CROSS INFECTION

THANKS so much for requesting so many reprints of the earlier issues of STAPH NEWSLETTER. As you will note above, this is the sixth of a continuing series. We have replenished our supply and will be glad to send you individual ones or the complete set. Just let us know which you prefer.

Did you know that the new Ninth Edition (1960) of "Control of Communicable Diseases in Man" now recommends standard regulations for prevention and control of hospital-acquired staph infections? Preventive measures emphasize strict aseptic technics and close coordination of all hospital control activities through your own Infections Committee. Paragraphs on reporting known staph infections to local public health authorities include, "2 or more concurrent cases on same hospital service or ward are to be regarded as an epidemic".

We do not have copies of this book but, if your library does not have it yet, it is available from the American Public Health Association, 1790 Broadway, New York 19, N.Y. (paper bound, $1; de luxe, $2.50).

Until recently our mail brought frequent queries on the "why" and the "what-to-do" of controlling staph through disinfection of the environment. Now, more and more requests are for specific instructions on "how to" disinfect efficiently.

So you'll be glad to hear that we have just completed a set of eight 3" x 9" "How-to-use" cards on O-syl®—with specific dilution and timing recommendations. Individual cards cover: general environmental disinfection; tuberculosis hygiene; disinfection of thermometers, of instruments, of catheters; disinfection in the operating room, in food service areas; and disinfection of blankets, linens, and diapers. Each card is handy for teaching and for posting. We'll be glad to send you as many sets of cards as you need—or, if you prefer multiple copies of one particular card, let us know when you write.

Dr. Ralph Adams' newest report on "Sterility in Operating Rooms" appeared in the March, 1960, issue of Surgery, Gynecology and Obstetrics. "At the end of 12 months, there had been 2 clean wound infections in 800 cases, 0.25 per cent." Culture plate illustrations reconfirm his contention that, "Sterility in operating rooms can be maintained solely by frequent repetition of bactericidal cleaning processes (disinfectant-detergent plus mechanical), isolation by physical barriers from the rest of the hospital, and bacteriologically protective coverage of surfaces which cannot be sterilized".

Lehn & Fink's Tergisyl® is the disinfectant-detergent used in this continuing study. Amphyl® disinfectant is used on all blankets.

A review of bacterial endocarditis cases covering ten years (1949-1958) at the Bailey Thoracic Clinic in Philadelphia revealed a significant increase in cases in the last 5 years, and, even more significantly, an increase in mortality. With the staphylococcus having replaced Streptococcus viridans as the causative agent, the study by Lisan and his co-workers (American Heart Journal, page 184, February, 1960) indicates not only that "cardiac surgery predisposes the valves and endocardium to superimposed staphylococcal infection" but that "resistant strains of staphylococci found in hospitals apparently have a predisposition for the endocardium of postsurgical patients".

Have you seen the annotated bibliography on control of staph infections published in the American Journal of Nursing, December, 1959? As far as we know, it is the most comprehensive review of available articles made to date. Pertinent films and books are also mentioned. This bibliography could be very valuable to your Infections Control Committee. We have a limited number of them available and will be glad to send you one. Please write soon.

The other day I used the word "sterilize" when talking to an O. R. Supervisor about L&F Instrument Germicide. Her immediate query was, "How can instruments be 'sterilized' by chemical disinfection which does not kill spores?" Here's how—Heat the L&F Germicide to the boiling point, immerse instruments for 20 minutes in the boiling germicide. This destroys resistant bacterial spores and viruses, including those of serum and infectious hepatitis. Of course, boiling water alone would not sterilize within any practical period of time, that is, in less than four hours. Boiling L&F Germicide sterilizes in 20 minutes. May we send you our new folder on this product?

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If you have a baffling infection problem, why not discuss it with us. Perhaps our technical advisors and research laboratories could help. And I, personally, would appreciate hearing from you.

Charles F. Manz

Charles F. Manz
General Sales Manager
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HOSPITALS
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editorial notes

—medication errors

AN EVER increasing emphasis on medical research has accelerated the introduction of new and complicated techniques of diagnosis and treatment. Additions to an already awe-inspiring array of new and powerful drugs are made almost daily. The resultant increase in the effectiveness of medical care is most impressive and heartwarming to the profession and to the public.

But in medicine, as in every field of human endeavor, progress has brought along with its welcome benefits a host of very unwelcome problems and hazards hitherto unknown. One of the most thoughtful and thought-provoking analyses of this subject may be found in a paper* read by David P. Barr, M.D., before the Section on Internal Medicine of the American Medical Association in June 1955. This paper should be required reading for all students and practitioners of medicine and nursing and for all hospital administrators and pharmacists. I quote Dr. Barr in brief:

"Today, when multitudes of new and relatively untried diagnostic and therapeutic procedures form an integral part of the practice of medicine, the admonition 'Be sure you do no harm' applies more than ever before. Diagnostic methods formerly simple are becoming increasingly complex and formidable . . . Therapeutic preparations are confusingly numerous and varied. In the lists of 1953, more than 140,000 medicaments were available to practitioners and 14,000 new preparations were added during the year. Accretion is still far greater than deletion, although it has been estimated that perhaps 90 per cent of drugs now in common use have been introduced within the last 25 years. Although incalculable benefits have come to mankind with the introduction of these newer diagnostic and therapeutic procedures, hazards of medical management have at the same time enormously increased. Not one of the occasionally indispensable diagnostic tests may be undertaken without risk . . . Furthermore, no agent that can modify the internal environment or organic integrity of the body can be used without hazard. As yet no drug has been found with a single action and no human body with a single reaction. Risks accompany the use even of those remedies that are regarded as safest."

Dr. Barr, in his discussion of the price that we must pay for modern management of disease, took pains to exclude from consideration all examples of carelessness, misconduct and malpractice—including errors in the administration of medications. Nevertheless, such errors have occurred in the past and, humans being what they are, they can be expected to occur in the future in medical practice outside and inside hospitals.

The chances of a medication or treatment being administered erroneously in a hospital have been estimated by various surveyors. Obviously, because of the tremendous number of medications and treatments being given to patients in hospitals today and the difficulties in securing accurate and comprehensive reporting of such errors as do occur, these estimates are no more than "guesstimates". One estimate is that medication or treatment errors occur in one out of approximately 17,000 times. This is certainly a low ratio. Nevertheless, any one of these errors might have serious consequences to a patient. All those who provide care for patients in hospitals obviously bear a heavy burden of moral, ethical and professional responsibility to prevent every medication or treatment error if it is humanly possible to do so. Quite apart from such basic considerations there is a practical aspect of the over-all problem which deserves serious consideration. This is the medicolegal aspect.

The American Medical Association-American Hospital Association Medicolegal Education Committee is currently pursuing a program aimed at having the medical staff, nursing staff and administration in every hospital cooperate in a continuing program of analysis and evaluation of procedures and practices involved in patient care to the end that incidents which might cause harm to patients and lead to claims and suits against doctors and hospitals may be prevented. The organization and operation of such a hospital committee has been described.**

Procedures and practices involved in the administration of medications and treatments are of particular concern at this time to all inhospital medicolegal education committees because of information indicating that claims and suits arising out of medication and

(Continued on page 124)

*Barr, D. P. *Hazards of modern diagnosis and therapy—the price we pay.* J.A.M.A. 159:1452 Dec. 10, 1955.

**Sadusk, J. F., Ludlam, J. E., and Groeschel, A. H. *Hospital-physician liability: a growing problem.* HOSPITALS, J.A.H.A. 33:36 July 16, 1959.

administrative research and improvement:

A 'Survival Item' for Hospitals

by A. A. LEPINOT

Public pressure to prove hospital efficiency, plus frequent technological changes, are making it imperative that every hospital have an organized administrative research and improvement program, the author asserts. He discusses how programs using industrial engineering techniques can be applied to hospitals, emphasizing such problems as program financing and coordinating, and special training needed by the person—assistant administrator or industrial engineer—responsible for the program.

THERE IS much truth in the idea that when we stop getting better, we stop being good. It is not difficult to continue to produce the same product or the same service. The difficult job is to improve it. The basic philosophy of administrative research and improvement is that perfection is never reached and that there is always room for improvement.

ADAPTING TO CHANGE

If this concept is accepted, administrative research and improvement becomes as important as the traditional management processes of planning, organizing, directing and controlling. Administrative research and improvement is even more important in organizations such as hospitals, which are subject to frequent technological changes. These changes make any organization more difficult to analyze and improve.

Many diagnostic and therapeutic facilities essential in hospitals today were not available five years

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ago. These require changes in physical space, plus new equipment, procedures, professional and technical personnel, and materials. Changes, which have been coming fast, will accelerate in the future because emphasis is being placed on medical research and on research in general.

We must not only try to improve what we now have but to adapt quickly to constant and frequent technological change. Even this is not enough; hospitals themselves must produce technological improvements and innovations by conducting research programs as part of their operations.

RESEARCH: A HOSPITAL ESSENTIAL

To maintain a respected position in modern society, we must demonstrate to the public that we are constantly trying to improve quality and reduce cost by studying and improving our operations. This does not imply that hospitals have been doing nothing in administrative research and improvement. Almost every hospital administrator can say that he has improved his organization. Also, some well organized and directed hospital administrative research and improvement programs are now in effect. Usually, however, the administrator and his assistants are so busy with things which they *must* do that they do not get around to things they would *like* to do. Administrative research and improvement are in this category of items put off.

More and more available evidence shows that a positive, organized program of methods and systems analysis or operations research is a vital, necessary part of every hospital operation. Equally important is a positive program of administrative improvement that constantly evaluates the psychology of handling people in the management process. Of parallel importance are research and improvement in the architectural design of hospitals, including over-all space and equipment utilization, and efforts to design completely new hospital equipment and materials. All these can be combined under the broad heading of hospital administrative research.

Industry has had to study carefully every productive procedure in order to control and reduce costs in a highly competitive market. Competitive pressure to reduce costs in order to maintain economic position has not existed among hospitals. Certainly hospital administrators and medical staffs have not sat by idly while costs have continued to climb. Some effective steps have been taken to help keep costs down. It is true, however, that recent spiraling costs have made it mandatory for hospitals to study carefully every procedure, including labor utilization, in an effort to control and reduce costs. Public pressure rather than the pressure of the competitive market is bringing this about.

Ways must be found to make hospital employees collectively more productive. The hospital budget consists of approximately 70 per cent labor; therefore, effective utilization of labor is a highly important factor. Hospitals operate on a 24-hour day, seven days per week basis which creates unavoidable labor standby service. These factors make it very important that all aspects of utilization of labor be given careful continuous study in the hospital. Invention of new equipment and introduction of new materials, especially disposables, should be objectives of hospital research programs. The paucity of constructive research in hospital design means that this also should be part of a research program in the hospital.

BUDGETING FOR FUNDS

The National Industrial Conference Board estimates that approximately two per cent of the cost of sales of industry engaged in manufacturing is allocated to research. It is commonly known that industries with good research staffs and programs are the most productive and have the lowest costs. Why should not hospitals budget for administrative research and improvement, including this cost in billings to patients and insurance companies? There appears to be every valid reason to do this. It would in turn stimulate a wave of administrative research and improvement in hospitals across the country. If industries regard research as an operating cost, why can't hospitals? A good program can be conducted in any size hospital for less than one per cent of the annual budget.

Industry uses industrial engineering techniques in studying their productive procedures, and these techniques have paid rewards. Many other organizations, including hospitals, have found that these easily understood techniques have wide application to their own problems. Basically, it is nothing more than an organized and directed program which uses a scientific approach to problem solving. The type and size of hospital, its current problems, and the over-all objectives set for its administrative research and improvement program will determine the techniques to be used. They will also determine which personnel should conduct research to facilitate the installation of improvements. No two organizations are likely to be similar in their requirements and available personnel. The main similarity is that all hospitals can benefit by conducting an administrative research and improvement program.

A CREATIVE ENVIRONMENT

The primary responsibility for an administrative research and improvement program lies with the hospital administrator and his line executives. They must generate a philosophy of operations improvement in the hospital. Full cooperation of the entire organization, including the medical staff, is required to make the administrative research and improvement program a success.

If administrator, line executives, department heads and supervisors appeal to the creative instinct present in all employees and properly motivate them, an operations improvement program will become vigorous and will be a source of job satisfaction to all concerned. In fact, positive administrative improvement results when administration, department heads and supervisors see that an employee's work gives him the fullest satisfaction possible. Certainly, recognition of his contribution in an operations improvement program is a plus quantity in job satisfaction.

Some hospitals have operated improvement programs entirely through the efforts of the adminis-

trator, assistant administrator, department heads, supervisors and employees. To be productive, the program must have organization and positive direction. Specific projects must be defined and approved. The person charged with the primary responsibility for carrying out a project must keep records of progress and make reports. The administration should provide frequent occasions to assess the research and development program. Goals must be set and publicity given to the program to maintain interest. Much valuable research and improvement can be carried on using this approach.

INDUSTRIAL ENGINEERING TECHNIQUES

Prior to initiating the program, it is essential that the administrator, assistant administrators, department heads and supervisors study the basic techniques and terminology of industrial engineering as applied to hospitals. Several universities offer short courses or institutes covering the subject. One or more of the staff can take the course and then give basic instructions to the rest of the staff. Methods improvement institutes are also conducted by the American Hospital Association. Some industrial engineering techniques with which the group should become familar are:

- Work simplification.
- Flow process diagram.
- Flow process chart.
- Form analysis and design.
- Standards of job performance.
- Traffic flow diagrams.
- Work survey questionnaires.
- Time and motion.
- Work distribution by time.
- Work distribution by personnel.
- Probability studies.
- Desk audits.
- Production control.
- Materials handling.
- Layout studies.

The staff should also understand the five "w's" in industrial engineering:

1. Why is the job being done and is it necessary?
2. What is being done and what is its purpose?
3. Where should the work be done?
4. When is the work done? Could it be done better and more economically at another time?
5. Who is to do the work?

In scientific problem solving, the six steps include identifying the problem, collecting facts, analyzing facts, developing alternative solutions, installing the best solution and following through to see that this solution works.

The key factor in the success of this type of program is the time available for carrying out the studies by the administrator, his assistants, department heads and supervisors. Operating department heads seldom find time for administrative research. This is even more true when interest and direction from the administration is lacking. An individual on a high administrative level who has sufficient time must handle the job of coordinating the administrative research and improvement activities of the hospital. Depending on the size of the hospital, he may be the administrator or assistant administrator, or perhaps a research associate trained in industrial engineering or another field.

COORDINATION RESPONSIBILITY

Responsibility for coordinating an administrative research and improvement program appears to be a good one for graduates of programs in hospital administration who are functioning at the assistant administrator level. As assistantships are now set up in hospitals, sufficient time undoubtedly would not be available to handle this responsibility.

In the first place, medium sized hospitals should have many more assistantship positions than exist in these hospitals. Usually, the administrator shoulders the full burden of administration or shares it with someone at a department head level. In these hospitals, there should be sufficient activity in an administrative research and improvement program to occupy all of an assistant's time. Experience of this type would be invaluable to the assistant, and the administrative research and improvement program would be of real and tangible value to the hospital. The same is true in larger hospitals, where assistantships are needed to coordinate administrative research and improvement programs.

A man with engineering and drafting training, plus management know-how, is of particular value in some aspects of a complete administrative research and improvement program. He is especially valuable in programs involving building design, over-all space and equipment utilization, and materials and equipment research. A number of the larger hospitals and medical centers have found it particularly helpful to employ an industrial engineer at the assistant administrator level. Some hospitals make particularly valuable use of medical electronics, including application of computers to medical and hospital care. Another area which involves engineering is research aimed at developing completely new hospital equipment and materials.

It is not too difficult for the research associate-industrial engineer to adapt to the hospital environment. The ideal, of course, would be for the industrial engineer also to take a course in hospital administration. However, sufficient interdisciplinary activity takes place to mutually benefit the administrator, research associate, research program and the hospital. In the large hospital and perhaps also the medium sized hospital, it is of value to have both an industrial engineer and a graduate in hospital administration working full time in the administrative research and improvement program. They complement each other. Responsibility for coordinating the program would depend upon the individuals involved.

DEFINING STAFF STATUS

The research associate should be a staff assistant to the administrator with no line responsibility. His role must be carefully defined so as not to conflict with that of the chief engineer and other assistant administrators. He must be aware of the social and professional framework of the hospital. He should study the social aspects of changes contemplated and consider how he would feel if he were in the position of the people affected by his recommendation. He must remember that some things which seem very clear to him are not so clear to the department head. The reverse of this is also true—espe-

cially of a department head who really knows his operation. Mutual patience and cooperation must prevail.

ROSWELL PARK PROGRAM

For the past five years, an industrial engineer has been employed at Roswell Park Memorial Institute at the assistant administrator level. He is assisted by a full-time draftsman and a typist. He is a staff assistant without line responsibility. Throughout the years, primary attention has been focused on physical improvements; however, we have also completed a number of operations improvement projects.

The first and most time-consuming project over an extended period of time was a space analysis. This included an analysis of the existing floor plans of all buildings to determine specific space allocations and utilization. Blueprints were revised to bring them up to date. Gross square foot area, net useable area, and nonuseable area were calculated. The departmental space allocations were specifically redetermined. All areas, including the new facilities, were designated by a new room and area numbering system, and a space coding system for departments was developed. A study of each department's activities was made and space allocations and detail layouts were prepared for both existing and new facilities.

The result is a space and equipment inventory with each unit of space and item of equipment on an I.B.M. statistical card; this provides space and equipment inventory control and utilization information. Many flow process diagrams and flow charts were made in this layout work.

At the time the space and equipment analysis and utilization study were made and the blueprints revised, a system of producing our own plastic room numerals and signs was developed. An engraving machine was purchased to do this work at considerable savings over purchasing commercially available numerals and signs.

There have been numerous other physical improvement projects including layout studies and flow charts on the employees' cafeteria, print shop, admitting department and snack bar. Also, considerable planning effort went into a new apartment building, animal breeding building and numerous research laboratory layouts. Completed operations research projects include a study of the scientific stores' shelving requirements and operations, photocopy requirements, redesign of the medical chart forms, parking lot design, telephone analysis and central dictation system.

Evidence shows that the savings realized in this program exceed many, many times the cost of the program. We have found that the work of the industrial engineer is facilitated if he handles some large and some small projects simultaneously. An unending list of improvements is yet to be investigated.

ADDITIONAL RESEARCH EFFORTS

It is encouraging to see that research reports of hospital improvement programs have been appearing more frequently in the literature. Costs have been reduced in the dietary department, central supply, operating rooms, laundry, and other departments as a result of a thorough research study of these operations. More applications of automation and electronic data processing to hospital operations are also being reported.

The U.S. Public Health Service, under the Hill-Burton Program, has set aside funds to be used for grants to conduct research relating to the development and utilization of hospital services, facilities and resources. One development resulting from research financed by one of these grants is the progressive patient care plan. Other important studies have been made under the program with significant progress reported.

NEW CONSULTING SERVICE

The American Hospital Association is now in the midst of a management consulting service supported as a pilot study by the Ford Foundation. The purpose of this program is to assist hospitals in developing criteria for evaluating their operations. It is primarily a counseling service without charge to hospitals. It will still be the responsibility of the individual hospital to make detailed research studies of its operations and follow up on improvements. It will be interesting to watch the effect of this program.

Several conferences under the auspices of the American Institute of Architects, American Hospital Association, U.S. Public Health Service and National Research Council have been held to focus attention on the need for innovations in hospital design and construction. Improvements are beginning to appear in some of the modern hospitals being constructed. Much more effort is needed in this direction and it appears that it can best be done in the hospital by persons closely associated with hospital operations.

Management consulting firms and hospital consultants have been responsible for many hospital administrative improvements when they have been engaged by hospitals. When the organizational or operational problem of a hospital is of sufficiently broad scope and complexity, the services of the management or professional hospital consultant will continue to be sought. ■

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Methods Improvement: Interim Report of the Committee on Methods Improve-

(Continued on page 125)

WALLS of this booth at the West Central Georgia Fair are lined with 20 photographs showing the helping hands of Upson County Hospital, Thomaston, Ga. The exhibit effectively pictured the many skills which share in caring for the patient.

A HOSPITAL'S

Pictures tell a powerful story of collective skill

GENTLE HANDS—strong hands—skillful hands that give life to your hospital." Photographs on this theme created a powerful display for Upson County Hospital, Thomaston, Ga. Twenty pictures, used in the annual hospital exhibit at the county fair, were aimed at showing the public the wide range of hospital activity that the patient never sees. The dramatic pictures, six of which are reproduced on these pages, show skilled hands at work in such varied areas as central sterile supply, emergency room, nursery, and operating room.

For the exhibit, the 11 inch by 14 inch photographs were mounted on 16 inch by 20 inch card stock. The exhibit area was lined with heavy cardboard; art tacks fastened the pictures to the three sides of the booth.

Chris J. Neubert, administrator of Upson County Hospital, reports that this display was the most successful effort the hospital had ever made in telling its story of unseen services. Both the excellent attendance at the exhibit and the public's enthusiastic comments attested to the effectiveness of the pictures. The local press, in highly recommending the exhibit, called the display a "work of photographic art".

The idea of portraying hands in action originated with the hospital administration. Purpose of the exhibit was to show the many hands that go into taking care of patients in hospitals—hands of which the patient is unaware. A complete list was made of all the possibilities for photographs and a local photographer was then asked to take the pictures. The editor of the local newspaper helped formulate

the "gentle hands—strong hands" title, which was mounted with the pictorial exhibit.

The hands of Upson County Hospital have now become the "hands" of hospitals all over the country. The pictures used in this display inspired the National Hospital Week poster and were used in its design.

Upson County Hospital has offered to lend its exhibit without charge to other hospitals who may want to develop the helping hands theme by means of a pictorial display. ■

THE VOLUNTEER WITH THREE

by MRS. ANNE GROSS

Because the volunteer is subject to supervision by three separate and distinct "heads" in the hospital hierarchy, the job of volunteer director requires continuous diplomacy, the author states. She describes specific problem cases to show that tact, indirect supervision and discussion are vital elements in the successful volunteer services program.

The volunteer with three heads is no blessing, even if she brings with her three pairs of eyes and six ears. One might think this would be a handy arrangement for a busy hospital volunteer program when several regular volunteers are absent, but on the contrary, it is a distinct disadvantage. The three-headed volunteer cannot maneuver on the simplest level without most careful guidance.

The "three-headed volunteer" exists only because the department of volunteer services is an administrative freak. The volunteer with three heads is the volunteer with three bosses—the head of the department which "hires" her, the head of the department which supervises her, and the head of the auxiliary which sponsors her as a hospital volunteer.

No other personnel in the hospital are so abundantly endowed with heads. The personnel department maintains only a loose, organizational connection with paid personnel once they are assigned to specific hospital departments. The line of authority runs straight and clear from each department head to each employee.

The volunteer does not fall into such a clear supervisory hierarchy. The first violation of normal organization is that the department which engages the volunteer does not relinquish control once she is assigned to another department; it maintains a continuous and significant relationship with her from the time she enters the service until she leaves. The director of volunteer services is responsible for her schedule, arranges her orientation, transfers her on occasion to new assignments, follows her performance on the job, sees that she is given adequate recognition, helps her solve her problems, decrees what she shall wear and how she shall conduct herself.

THE MOST IMPORTANT HEAD

The volunteer knows that the director of volunteer services is her most important head. But no sooner is she in uniform than she learns that she has a very important second head—the head of the department to which she is assigned. This department head supervises her performance, often personally trains her, checks up on her and corrects her. Simultaneously, the volunteer may become aware of her third head in the guise of the auxiliary president, the auxiliary chairman of volunteers or her service chairman. By the latter is meant the chairman of a specific group of volunteers, such as the chairman of the clinic volunteers. In hospitals with service auxiliaries, volunteer chairmen assume varying degrees of responsibility within the department of volunteer services.

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This article is based on a paper given by the author at the annual meeting of the American Hospital Association held last August in New York City.

HEADS

The director of volunteer services must thread a skillful path through the maze of interrelating responsibilities, not only to protect the volunteer from bewilderment but also to ensure her own department's control of the volunteer program. Because the director assigns volunteers to many departments of the hospital, she must know the business of each department—what it is and how it is conducted. The director must be neither too aggressive nor too retiring in following the travels of the volunteer in service. She cannot permit any other department head to usurp her rightful place as the focal supervisor of a particular volunteer. But neither can she usurp a department head's responsibility to supervise all personnel within the department, both paid and volunteer.

SCOPE OF THE SERVICE

The scope of the volunteer services department is as large as the number of departments to which it assigns volunteers. Its philosophy spreads throughout the hospital, propagated quietly by every cherry red or yellow or green uniform that reports to a volunteer post. Administratively, the volunteer services department becomes a freak, different from every other hospital department whose responsibility is strictly limited to its own affairs.

For these reasons, the director of volunteer services must learn to be diplomatic, to obtain by indirection what the ordinary supervisor can obtain directly. She must "sell" the department to the volunteer and the volunteer to the department and the auxiliary chairman to both. She must "sell" herself to all three as the instrument of bringing them together. She must correctly estimate what share of supervision falls to each supervising agent and then tackle the tricky problem of seeing that each one does the job. This may involve "walking on eggs", for the line between interference in a department's affairs and assumption of responsibility for a volunteer's welfare can be needle-thin.

A THORNY PROBLEM

Some specific problems can give an idea of the tact required in supervisional jurisdiction. In the admitting department at Mount Zion Hospital, two volunteers report for duty each afternoon. Job descriptions worked out in advance by the director of volunteer services and the head of the admitting department are quite clear. One is a waiting room receptionist, the other answers one of the telephones in the admitting office; both services free the professional staff for other duties.

On one occasion, my office arranged a substitution for the regular Tuesday afternoon volunteer on the admitting department telephone. The replacement had been on the job hardly half an hour when she appeared in my office in a state of agitation. The volunteer receptionist had requested patients' room numbers from her, a procedure at variance with the normal duties and job description. The receptionist said they always did this on Tuesday, so the volunteer substitute had cooperated by getting room numbers from each patient's chart. On the sixth or seventh time, a member of the paid staff saw her and reminded her sharply that she was not to touch the charts.

This classic situation involved departure from the job description by several volunteers and an apparent lack of alert supervision within the department. Fortunately, the volunteer reported her difficulty to the volunteer director promptly, because relations with another volunteer were involved in the difficulty. However, she might, with equal logic, have reported her difficulty to the head of the admitting department.

In the over-all sense, a director of volunteer services always remains technically responsible for how a volunteer performs on the job. But in a specific situation, the head of the department takes immediate responsibility for what is happening in that department.

In this case, consultation with the regular volunteer receptionist confirmed a Tuesday deviation, encouraged by one of the paid staff, from the job description. The volunteer director requested that the volunteer temporarily revert to the approved way of obtaining room numbers—from the staff. An appointment was then made for a discussion with the head of the department. The department head had known this change in routine took place occasionally. Because some of the volunteers were so competent and because it was a great help to her staff, she winked at it.

VALUES OF THE DISCUSSION

We reworked the job description, reviewing why volunteers were not generally permitted to see charts, and difficulties in delegating different duties to different volunteers and in allowing paid staff to change procedures without consulting the department head. In the end, we reached the original job description. The head of the admitting department clarified the situation with her staff, both paid and volunteer.

In addition, the director of volunteers followed up with the volunteers to make doubly sure the difficulty was not repeated. The chairman for the admitting volunteers and the volunteer director drafted a memorandum to admitting department volunteers, stress-

ing strict adherence to the job description. At an inservice meeting of this same group of volunteers, the episode was aired and discussed to everyone's satisfaction.

Consultation between supervisors is essential for solving such problems. The department head must be accorded her rightful responsibility within her department. The chairman must not be bypassed. In this case, the director of volunteer services pointed out a problem so the department head and the chairman of admitting department volunteers could rightfully share in its solution. Anything further would have been interference and anything less would have been a lack of adequate supervision.

SUPERVISION BY INDIRECTION

Supervision by indirection avoids ruffled feelings and results in good rapport between paid personnel and volunteers, particularly where dual responsibility is involved. More important, it gets the job done. One director of volunteer services, even with herculean stamina, can never give all the direct supervision needed by volunteers throughout the hospital.

Indirect supervision protects the rights of the volunteer on the job and ensures adequate supervision. It is fascinating to observe that some department heads expect volunteers to perform tasks without supervision that they would never assign to a paid employee without strictest supervision.

Another example of supervision by indirection involves the role of chairmen. We have, at Mount Zion Hospital, a group of volunteer hostesses serving in the x-ray department; they keep patients as comfortable as possible while they are waiting. Their props are magazines, cigarettes, coffee and overhead television screens with individual earphones. Each hostess is chosen because she is warmhearted and sensitive to patient psychology. Yet for some reason, we had trouble with this particular service. Our hostesses complained about other department personnel, let supplies run out without replenishing them, missed their shifts without notification. Although well-placed, their morale was low. They had as much department supervision as one could expect in this type of "self-starter" job. The answer had to lie elsewhere.

It could not rest with direct supervision by the director of volunteer services. We could not ask any further supervision by the x-ray supervisor. Even though it was only a small group of five, we decided to try a volunteer chairman. And work it did, like magic.

MORALE: FORTE OF THE CHAIRMAN

Attendance improved, enthusiasm ran high, new ideas were born, and patients began calling the volunteer office to thank us for the kindness shown them by the hostesses. The chairman helps coordinate schedules, follows up with individual volunteers, visits them on the job and makes their service seem even more important. Thus, a new chairman joined the corps of trained auxiliary chairmen who serve as supervisory aides to the department of volunteer services at Mount Zion Hospital; they are indispensable tools of supervision by indirection.

There are occasions when it appears that supervision by indirection is not working. On a particular issue, the director of volunteer services may not be in agreement with the head of a department who is using volunteers. The director of volunteer services may find an auxiliary chairman overstepping her authority or lying down on the job. At these times, the volunteer director looks up her own immediate supervisor on the organization chart. In the first case, it may be the assistant administrator or the administrator; in the second, the chairman of volunteer services or the president of the auxiliary. It is unfortunate to have to refer what is essentially a problem of administration to the supervisors who have hired you to handle those problems. Still, it is better to know when to ask for help than to flout the rules of indirect supervision.

Another situation which poses some uncomfortable moments for volunteer directors is the face-to-face supervision of the volunteer. No matter how we rationalize, we cannot escape the cold fact that the relation of the director of volunteer services to the volunteer is different from that of the department head to the paid employee. Less tangible supervision exists over someone who volunteers services than over someone who sells services.

The moment the volunteer walks in the door, the director of volunteer services becomes involved in public relations with the community. It is not as easy to turn away a volunteer or tell her she looks sloppy or, on occasion, to fire her, as it is to do these things to a paid employee. But at times we must do these things. One searches for new ways to solve the problems left in the wake of the volunteer who takes a sudden three-month jaunt to Europe or who cancels out at the last minute because the baby is ill. These are the volunteer's prerogatives as they are not the employee's; they do not demand the disciplinary aspect of supervision. It is perhaps less difficult to undertake this disciplinary function than some people assume, but unquestionably, it has its sticky aspects. The problem of appearance can be attacked in groups so it isn't taken personally. One refuses the volunteer by not having the desired position on the preferred day of the week. In other words, one uses indirection.

Coordination is a major part of the supervision offered by the department of volunteer services. Keeping the channels of communication open at all times is the major part of coordination. If the door to the volunteer services department is always open and if the traffic flows in and out, vital channels of communication are open.

Welcome the volunteer who bursts in with a crisis. Welcome the chairman who wrings her hands in despair over some volunteer's behavior or some department head's sharp word. Welcome the department head who comes in to complain about the personality of one of the volunteers assigned to her. For as long as these people bring their problems to the volunteer office, the director of volunteer services is in firm control of the volunteer program. Then and only then will the three-headed volunteer report cheerfully and confidently to her assigned position, week after week. This is the reward for supervision through indirection. ■

SELF-EMPLOYMENT . . . is it worth the price?

by SUMNER PRICE, M.D.

Nonsalaried specialists in hospitals should resurvey the main objective of their self-employment, the author believes. He shows why present liberal personnel policies and fringe benefits make it advantageous for specialists to achieve a salaried, but nonexploitative, relationship with hospitals.

ANESTHESIOLOGY, pathology, and radiology are accepted branches of the art of medicine, in spite of the fact that early discoveries in these areas were made primarily by men of science who were not medical men at all. However, the application of these scientific discoveries to medical practice has led to their acceptance as part and parcel of the specialized practice of medicine. There are two additional basic reasons for their inclusion: (1) only physicians are granted a license to practice medicine; and (2) economic reasons justify a fee for service rendered.

THE FIGHT FOR STAFF STATUS

For many years, there was considerable evidence of exploitation by hospitals of their anesthesiologists, pathologists and radiologists. This exploitation was for the purpose of raising revenue to defray deficits in nonrevenue-producing departments. However, the chief objective of these specialists initially was to improve their staff status—economics was only a side issue.

Some of the first steps toward establishing staff status for pathologists in the hospital were made at the New York State Pathological Society, where early discussions by pathologists involved whether persons other than physicians should operate laboratories, how exploitation of the pathologist by the hospital executive could be avoided, and even whether pathology could be considered the practice of medicine.

The original fight, then, was for recognition and status in the profession. Once this status was gained from their medical colleagues, pathologists turned their attention to economics. Pathologists would first look at the fees paid surgeons—surgeons who wouldn't operate without the pathologist's advice—and then would look at their own empty pockets and wonder why they shouldn't be paid more. From this came the idea that it was unwholesome to work for a salary, despite the fact that many of the pathologists' best teachers had been salaried personnel.

As a result of exploitation by hospitals and the denial of adequate staff status to anesthesiologists, pathologists and radiologists, a strong effort was made to make these specialties self-employed. Self-employment was urged as a means to obtain the respect and status to which they were justifiably entitled.

LIBERAL PERSONNEL POLICIES

Regardless of whether there has been exploitation in the past, present factors require a resurvey of the main objective of self-employment. We should see if a working relationship for the future can be maintained which will avoid exploitation by either party. Many hospitals now have liberal personnel policies which are not available to the self-employed, except by special arrangement. Many fringe benefits are attractive because they assist in developing security for the future. Practically any of them may be purchased by the self-employed person. But experience indicates that the so-called rugged individualist either procrastinates or does not remember to look after his future until he finds he is left out of something provided for hospital employees. Then the fringe benefits begin to look more attractive. The self-employed individual also begins to realize that these benefits, in part, have been contributed by the hospital, and that they do cost money.

Using personnel policies of The Queen's Hospital, Honolulu, to illustrate this point, here are some employee benefits to which the self-employed physician is not entitled:

Paid vacation. The self-employed physician is not entitled to the 30-day annual vacation allowance, and he is required to hire his own vacation relief. As a result, his vacations are apt to be less frequent than they should be.

Travel allowances. These permit attendance at mainland institutes or conventions at hospital expense. In the pathology department, for example, the department head (and his associate on alternate years) is provided with a travel allowance and per diem costs for educational purposes, for 30 days

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in addition to his 30 days of paid vacation.

Sick leave. Leave with pay is 12 working days per annum, and may accumulate up to 60 working days (the equivalent of three months).

Hospitalization insurance. Complete coverage in semiprivate accommodations is given without cost to the individual for 30 days in any calendar year. A substantial discount is given for catastrophic illness.

Group life insurance. A present maximum of $10,000 is offered, but the hospital is considering raising this to $20,000. This may also be purchased through medical societies or the various colleges, but, in some cases, there is a desire for this additional low-rate coverage.

Social Security. This is available for the self-employed, but it involves an extra premium, plus extra bookkeeping.

Tax deduction. Federal and state income taxes are deducted at the source for salaried employees. This does not avoid payment of any taxes, of course, but a regular monthly deduction makes the quarterly payment of estimated taxes seem less severe.

Retirement pension plan. A self-employed person can buy an annuity from many insurance companies, but such a program is seldom set up at an early age.

Liability insurance. Employees get protection under the hospital liability policy. Liability insurance may be obtained through the county medical society by the self-employed physician, but sometimes this is inadequate or not kept up to date.

Tax exemption. Employees get exemption from certain other taxes for which the hospital is not presently liable. In Hawaii, for example, there is a three and a half per cent tax on the gross income of self-employed persons without allowing deductions for necessary expenses. Hospital employees have not been subject to this tax.

SELF-EMPLOYMENT DISADVANTAGES

Several incidents have occurred recently that have seemed to demonstrate some of the disadvantages of being self-employed. In one instance, an individual wished to join the pension plan. However, he could not do so because the plan had been set up with the employer making a contribution of three per cent and the employee four and one-half per cent. Although the individual had worked at the hospital for 16 years, there was no way of establishing past service benefits except on base salary. Since this could not be done, he lost all past service benefits, and was deemed ineligible for future benefits until a base salary could be established upon which an assessment might be made. The hospital management does not object to paying a substantial base salary plus a commission, but requires that the recipient be an employee. This individual possibly has another 20 years before retirement and he now feels the need of security. He wants to participate in the plan and still remain self-employed, but it cannot be done.

Sums relinquished in retirement benefits by self-employed specialists are sizeable. The radiologist at our hospital recently calculated what he could have expected in retirement benefits if he had been a salaried employee. The amount —more than $1000 per month— could have provided him with postretirement security.

In another instance, an individual performed a service for an outpatient. Six months later it was claimed that an x-ray film had been read incorrectly and that an unrecognized fracture had been present which later necessitated surgical treatment. The case was settled by agreement for $3000 against the hospital liability policy because the radiologist carried no liability insurance. He probably should have carried some insurance apart from the hospital policy, for suppose the hospital had insisted he was self-employed?

There are advantages and disadvantages to self-employment, but it is worth another look. It certainly doesn't seem the least bit unethical to suggest that others take a look. Maybe it is true that some have "bought a pig in a poke" by denying themselves employee status with its special benefits, and by gaining the honor of paying taxes unnecessarily.

In Hawaii, Kaiser Hospital has recently been denied nonprofit status in real estate exemption. Where office space is rented to physicians (radiologists or pathologists), the hospital is considered a commercial enterprise. Even though only part of the building is devoted to commercial enterprise with profit to an individual, the entire hospital building and grounds has been deemed taxable by the tax commissioner. This could well put an institution and an individual at a great disadvantage, because buildings are appraised at 70 per cent of present-day value and the real estate tax rate is more than $15 per $1000 value.

THE ETHICS OF A SALARY

The question raised here, of course, is whether a physician can ethically accept salaried employment from a hospital. My conclusions on this are based on 25 years experience as a pathologist; I have worked for hospitals only on salary arrangements.

I have never been in sympathy with the idea that the ability to practice medicine has a specific relationship to any system of charging fees. If a salaried specialist is exploited, it may well be his own fault. I never received a salary increment without asking for it, but no requested increase was ever denied. Certainly, general practice would have been more rewarding financially. In fact, during my first year of general practice (1925), I earned more money than in any of the following 20 years, when I was practicing pathology. But there have been other satisfactions in practicing pathology which money could not supply.

In 1950, hospital administratorship devolved upon me; it has been a job even more challenging than pathology. It is a job which a layman with adequate training could do (and according to some, could do better), but it involves administrative procedures which fringe on the practice of medicine and which partially direct the treatment of the patient. It is a matter of executing rules and methods according to judgment. Both hospital administration and medicine are a matter of education, experience and judgment to guide patient treatment and to assure good patient care. Yet no one protests that an administrator should not work on a salaried basis. ■

PART TWO OF A TWO-PART ARTICLE

A CRITICAL INCIDENT STUDY OF HOSPITAL MEDICATION ERRORS

by MIRIAM ARONSTEIN SAFREN and ALPHONSE CHAPANIS, Ph.D.

In Part 1 of this two-part article, which appeared in the last issue of this Journal, the authors reported on a study of 178 medication errors and near errors in an 1100-bed hospital during a seven-month period, listing the major causes of these errors.

In this concluding part, the authors present their recommendations for reducing hospital medication errors. These include specific recommendations pertaining to (1) written communication, (2) medication procedures, (3) the working environment and (4) education and training.

THIS SECTION contains recommendations aimed at the design of a safer and more efficient medication system. These recommendations are based in large part on the data reported earlier, in part on supplementary observations collected by the investigator during the study and in part on intuitive insights into the special problems of the medication system in a large hospital. They are grouped under four major headings:

1. Recommendations dealing with written communication.
2. Recommendations dealing with medication procedures.
3. Recommendations dealing with the working environment.
4. Recommendations for training and education.

Before turning to specific recommendations, however, it is important to state explicitly a general premise which must underlie any thinking about this problem: The entire medication system must be designed to take into account human limitations and weaknesses. Nurses are not automatons. They are people, with all the human frailties and weaknesses of people in general. A completely error-free nurse is an ideal which can never be attained, and any medication system which assumes that personnel can be completely error-free in any and all circumstances is bound for trouble. Instead, attention must be focused on techniques and procedures which, by their very nature and design, reduce the probability of human misinterpretation and error.

Miriam Aronstein Safren is a research fellow and instructor in the department of psychology, the Johns Hopkins University. This thesis was submitted to the faculty of philosophy of the university to meet the requirements for an M.A. degree. Alphonse Chapanis, Ph.D., is professor of psychology and industrial engineering, the Johns Hopkins University.

WRITTEN COMMUNICATION

Careful examination of the incidents collected in this study and of the causes contributing to these incidents shows that one of the major difficulties with modern medication procedures is poor written communication. Drugs with similar names but different usages, confusing nomenclatures, illegible handwriting, drug labels so small as to be scarcely visible, abbreviations that resemble each other—all these are examples of poor written communication which almost literally invite human error. For this reason, the more important recommendations resulting from this study have to do with this serious deficiency in hospital practice.

1. *The system of drug nomen-*

(Continued on page 65)

County-wide alert unites community's disaster

by ROBERT W. WALKER

Hospitals need practice disaster alerts to test the practicality of their plans and to train employees and volunteers, the author states. He describes the problems and steps involved in planning a county-wide alert with the help of civil defense, city and county officials, and community organizations.

NEARLY EVERY HOSPITAL has its own disaster plan on paper, but unfortunately, few hospitals or communities have done more than read the articles and draw up a plan.

TEST THE DISASTER PLAN

Actual practice drills of these paper plans are vital; original plans always need considerable revision after actual experiences. A full dress disaster alert tests the practicality of the paper plan and familiarizes each employee with his duties.

The problems we encountered in planning for a county-wide alert may assist other communities in making such plans.

In Paris, Ky., we have two hospitals—one a 96-bed general hospital and the other a 110-bed state tuberculosis hospital. A 200-bed complete emergency hospital is stored on the grounds of the tuberculosis hospital for civil defense. The county population is 18,000; the population of Paris is 7000.

Our county civil defense organization is probably typical of most county organizations. The director is a hard working volunteer; when we began our plans most of his organization, because of public apathy, was just on paper. Both Paris hospitals also had integrated, but untested, disaster plans.

We at the tuberculosis hospital decided to test our plan by organizing a mock disaster in our hospital. The general hospital and civil defense authorities would be invited to participate, thus making it a county-wide affair.

Our first step was to consult administrators of the Lexington, Ky., hospitals, who had organized this type of alert two years previously. The Lexington administrators told us an authority conflict exists between civil defense and the military. They suggested whom to invite to the first meeting, and gave us samples of the specially designed tags they had used to identify casualties. After assimilating their information and printed material, we called a February meeting.

MEETING NO. 1: FRUSTRATION

The mayor, county judge, coroner, the civil defense director, president of the medical society, and administrator and director of nurses at the general hospital were invited to this meeting. The medical director, administrator, and assistant administrator of the tuberculosis hospital attended.

The meeting got off to a very bad start, since the county judge and the coroner could not attend. The administrator of the tuberculosis hospital explained the purpose of the meeting. He then announced that the assistant administrator would help plan and carry out the alert if everyone was agreeable. They weren't!

The civil defense director stated it was the duty and responsibility of civil defense to plan and coordinate all services in case of an emergency; that hospitals had nothing whatsoever to do with emergencies until the casualties

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VOLUNTEERS carry casualties from the disaster area of a local plant during a county-wide practice alert in Paris, Ky. A fire and explosion disaster was practiced, because this type of alert could best test the ability of hospitals and local agencies to handle casualties on short notice.

(BELOW) IN THE admitting area of the State Tuberculosis Hospital, Paris, Ky., a member of the auxiliary collects belongings from casualties. Office personnel are recording the necessary sociological data about each casualty on their identification tags.

plans

arrived at their doors. All others present agreed with this premise; however, none of them had any idea what to do in case of disaster. The civil defense director stated that his plan was completely worked out—on paper. It was discovered that the civil defense physician, who was expected to coordinate all medical and hospital services, had never mentioned it to either the hospitals or the medical society.

This first meeting brought nothing but a spirit of frustration. However, another meeting in two weeks was agreed on.

MEETING NO. 2: THE AIR CLEARS

Representatives of the Boy and Girl Scouts and Red Cross were invited to the second meeting. A new civil defense medical officer had been appointed by the civil defense director; he discussed disaster problems with the other physicians and hospitals.

For the second meeting the air was considerably cleared. It was agreed that the group would act as a steering committee; all planning outside the hospitals would come through the civil defense director. Concrete plans, subject to future revision, were made.

The disaster would take place on Thursday, May 14th, at 1:30 p.m. Thursday was set because most physicians' offices were closed on that afternoon. The 1:30 hour was used so the "casualties", who would be factory workers, could participate and return to the plant before the shifts changed. Waiting until May gave the new civil defense medical officer time to perfect his organization.

The disaster would be local in nature—a fire and explosion at a local garment factory employing approximately 350 persons. Before deciding on this particular type of disaster, three other possibilities were discussed.

CHOICE OF DISASTER

The first was a local atomic attack. This we discarded as unlikely. If an attack did happen, we knew we would be in no condition to practice what we had learned.

The second was an atomic attack of Louisville or Cincinnati—85

miles distant, or Ashland—100 miles distant. The influx of casualties following such a disaster would of necessity be a long-term proposition with many hours elapsing between the time of the attack and the arrival of casualties. This type of disaster was abandoned, since the situation would require more planning for long-term housing and feeding than for immediate hospitalization of large numbers of emergency cases. The third possibility—a flood or tornado in some adjacent community—was also discarded for these reasons.

The local fire disaster, with only minutes of warning, would test the abilities of the two hospitals to receive many casualties on extremely short notice, and also test the efficiency of the fire and police departments, civil defense officials, and all auxiliaries.

There would be 41 casualties; 20 of the more serious would be sent to the general hospital and 21 of the less serious to the tuberculosis hospital.

The physicians were asked to prepare a list of injuries that could be expected in an explosion and resulting fire. By mutual agreement it was then decided which patients would be sent to each hospital (see Figure 1). A sprinkling of more serious cases—fractures and severe scalds—were allocated to the tuberculosis hospital to give the personnel experience in handling all types of cases.

Injuries to be treated at the general hospital

1. Extensive burns of face and hands.
2. Chest — penetrating wound with shock and bleeding.
3. Laceration of eyelid and eye.
4. Pelvic fracture.
5. Bleeding from chest; dying on arrival.
6. Laceration and fracture of skull.
7. Fracture—ribs and sternum; pneumothorax — left.
8. Internal injuries—shock.
9. Fracture of left femur (compound).
10. Crushed right foot.
11. Fracture of jaw mandible.
12. Contusion of head; unconscious.
13. Laceration—deep bleeding of right arm above elbow.
14. Dislocated left shoulder with fracture of left clavicle.
15. Fracture of right upper arm.
16. Fracture of left lower arm.
17. Simple fractures of both tibias (lower leg).
18. Crushed foot—left.
19. Laceration of face.
20. Laceration of head and neck (across the nose).
21. Laceration of left thigh (major).
22. Compound fracture of left thumb.

Injuries to be treated at the tuberculosis hospital

1. Scald of face.
2. Burns of both knees and shins.
3. Laceration—left wrist—bleeding.
4. Simple fracture of left wrist.
5. Scalds of thighs.
6. Minor burns of left leg.
7. Minor burns of left arm.
8. Minor burns of fingers.
9. Burn right arm (minor).
10. Tip of nose burned.
11. Back of neck burned by steam.
12. Minor burns of right leg.
13. Burn left arm (minor).
14. Burn—hand and face (minor).
15. Minor burn of right hand.
16. Burned right hand, 1st degree.
17. Minor burn of left hand.
18. Right ear burned.
19. Burned finger.
20. Simple fracture—lower left leg.
21. Fractured right ankle with lacerations.

Figure 1—Casualty list for the mock disaster.

STORAGE OF SUPPLIES

Next, identification tags, splints, bandages, and stretchers were discussed.

Stretchers for civil defense were being stored in the emergency hospital. However, permission to use them probably would have been difficult to obtain; also, they were stored so inaccessibly that it would have taken an hour to reach them. We therefore obtained 12 stretchers from the state division of surplus property. These are permanently stored in an unlocked room in the general hospital where they are always available.

Old sheets donated by the hospitals were made into roll bandages by the Red Cross and stored in the same place. Lumber companies donated plyboard which the hospital maintenance departments made up into splints to be stored with the bandages and stretchers.

We decided to use identification tags similar to those used in Lexington (see Figure 2). Each heavy cardboard tag is five inches by eight inches, with a hole in the top for a long string. The bottom two inches of the tag is perforated so it can be detached. The tag is printed to record information on front and back.

We arranged to have 1000 tags printed. Their $30 cost was shared by the city and the Red Cross. A Boy Scout troop pasted the cloth rings around the holes and looped 24 inches of string in each card. The tags were then prenumbered top and bottom and stored at the general hospital with the stretchers, splints and bandages.

Specific duties for each key individual and organization during the alert were then decided. The civil defense director would stay in civil defense headquarters in the city office to direct the operation. All requests for services and supplies would come through him.

The fire department would proceed directly to the fire. City police and the sheriff's office would be in charge of traffic control at the scene of the disaster, on the routes leading to and from both hospitals and at the hospital entrances. The Boy Scouts and Girl Scouts would assist with traffic control and parking at the two hospitals.

Trained male Red Cross aides were to assist at the disaster scene

PRINT ALL INFORMATION
MUST BE SECURELY ATTACHED TO PATIENT

Name _____ Age _____ Tag No. _____
Race: W ___ N ___ Other ___ Sex _____ Religion _____
Address _____ Phone _____
Nearest Kin _____ Relationship _____
Address _____ Phone _____
Principal Diagnosis:

Order of Care: Urgent ☐ Less Urgent ☐ Least Urgent ☐
Surgery Major ☐ Surgery Minor ☐ First Aid Station ☐

TREATMENT ORDERED	GIVEN BY	TIME	DOSAGE

TEAR OFF AND GIVE TO FRONT OFFICE

Name _____ Tag No. _____
Race: W ___ N ___ Other ___ Sex _____ Religion _____
Address _____ Phone _____
Nearest Kin _____ Relationship _____
Address _____ Phone _____
Diagnosis _____
Disposition _____
Date _____ Hour _____ Signed _____

Name of Hospital _____ Blood Type _____

Final Diagnosis:

Final Disposition:
Admitted _____ Time _____ Date _____
Transferred to _____ Hospital _____ Time _____ Date
Transferred to _____ Shelter _____ Time _____ Date
Died _____ Time _____ Date _____ Disposition _____
Discharged _____ Time _____ Date _____
Lab.

X-Ray

Signed

Final Disposition:
Admitted _____ Time _____ Date _____
Transferred to _____ Hospital _____ Time _____ Date
Transferred to _____ Shelter _____ Time _____ Date
Died _____ Time _____ Date _____ Disposition _____
Discharged _____ Time _____ Date _____

Signed

Figure 2—Front and back views of the tags used to identify casualties.

and act as stretcher bearers at the hospitals. Auxiliary members were to help in tagging, collecting belongings, and as messengers in the hospitals.

The civil defense director would have ambulances, station wagons, and school buses available to transport casualties. The civil defense medical officer was to arrange all physicians in the community into three-man surgical teams, and to assign them where needed when the disaster occurred.

The principal means of communication were to be the telephone connected with civil defense headquarters, two-way radios in police cruisers and sheriff's cars, and the local radio station. Internal arrangements in the hospitals were left up to each hospital.

The alert would be given no advance publicity. Instead, the civil defense director would tape a recording to be played on the radio station at exactly 1:30 p.m., telling the public what to do and stating that this was a practice alert.

One other meeting was scheduled for May 7, one week before the alert. By then both hospitals were to have their internal plans perfected and final plans could be discussed on arrangements outside the hospitals.

Administrators and assistants

THE ASSISTANT administrator at State Tuberculosis Hospital processes some of the casualties in the admitting area. Congestion in this area became a critical problem during the alert, because most of the casualties arrived in a very short period of time.

from the two hospitals met and discussed the planning within the hospitals. The general hospital representatives decided to make plans for the alert with their department heads, but would wait until after the May 7 meeting to have dry runs within the hospital. We at the tuberculosis hospital, however, decided to have dry runs prior to the May 7 meeting, since we might gain something from these experiences that would alter our plans for the over-all alert.

To implement this decision, the assistant administrator, using the printed hospital disaster plan as a guide, assembled all department heads and the medical director to "walk through" the procedure. This took approximately 15 minutes, and accomplished very little.

A more realistic approach was then taken. Using two hospital employees as "casualties", the on-duty personnel participated in a practice which began with the stretchers at the front door. It was then that we found the procedures outlined in the printed form were not practical in many cases. This practice was repeated two or three times, with changes in individual employee responsibilities, until a practical system had been worked out.

Three days before the final meeting, the hospital staff met to discuss the faults that had been shown during the dry run. Department heads' responsibilities were discussed in detail and noted in the minutes so each department could discuss them later.

MEETING NO. 3: COMPLETED PLANS

At the May 7 meeting all arrangements for the disaster were analyzed.

At this meeting the civil defense director read a copy of the tape recording to be played over the radio. It ran approximately two minutes and stated, once at the beginning and once at the end, that this was a practice alert. The rest of the recording instructed the public in what to do while the alert was in progress. He then reported that all ambulances, station wagons, and two school buses would be available and that a civil defense ambulance from a nearby community would be alerted.

When notified by the civil defense officer, the civil defense medical officer reported that he would immediately dispatch a vehicle to transport emergency supplies from the general hospital to the disaster scene. He would proceed to the disaster. All physicians had been organized into three-man surgical teams and been advised of their assignments.

Red Cross aides already furnished with civil defense identification bands would be ordered to report immediately to the disaster scene to help with first aid and ambulance loading.

Police had worked out a standard route for ambulances to follow to and from both hospitals. These routes would automatically be blocked off in case of disaster. The complete police force and sheriff's office, both night and day shifts, were to be utilized during this period.

Eight older Boy Scouts and eight Girl Scouts were available to assist at each of the two hospitals.

DISASTER COMMUNICATIONS

The telephone company, after numerous discussions, agreed that upon being advised of an alert no incoming calls would be placed to either of the hospitals for 15 minutes. The hospitals would notify their off-duty employees by telephone and the civil defense director would notify the radio station to advise all off-duty employees and auxiliary personnel to report immediately to their respective hospitals.

The two hospitals would notify the auxiliary president of the alert by phone; she in turn would advise her personnel to report. All telephone communications were to be discouraged during this interval. Official calls would begin with the phrase, "This is a disaster alert call." Telephone company operators would place all such calls immediately.

Should either hospital require supplies or personnel which were available at the other hospital, they would contact the civil defense director instead of communicating direct.

The management of the garment

(Continued on page 126)

THE CIVIL defense officer administers emergency first aid to a casualty at the disaster scene. In addition to the county civil defense organization, such groups as the fire and police departments, hospital auxiliaries, Boy and Girl Scouts, and the medical society cooperated with hospitals on the practice alert.

HOW TO ORGANIZE A DEPARTMENT HEAD MANUAL

by HARRY J. WERNECKE JR.

A department head manual, the only sure method of keeping hospital policy information available and up-to-date, has distinct advantages for department heads, the administrator and the hospital, the author states. He explains these advantages and outlines the steps in preparing an efficient manual.

BEING ASKED questions of policy can be a frequent experience for the hospital administrative staff. Probably every administrator has been asked the question, "We had a problem similar to this last year. What did we do about it then?"

Administrators may wonder why department heads seek answers to these elementary policy questions. The probable answer is that department heads ask elementary questions because that is the easiest way to get answers. What is needed is an easier available method.

AN AUTHORITY ESSENTIAL

A department head manual is the only sure means of keeping up-to-date policy information and key procedures at the finger tips of each department head. This information is essential to his authority and responsibility. A department head manual, supplementing other means of communication, will go a long way toward developing the department head to be the true manager he should be.

Having policies in writing and available to all department heads and administrative staff is of distinct advantage to department heads, the administrator, and the hospital in the following ways:

1. Written policies save time because the same decisions don't have to be reached over and over again as similar problems arise.

2. Uniform application of policy throughout the hospital is encouraged because all department heads have the same written version of the policy. Written policy also guides department heads into taking similar action in similar situations.

3. Department heads, armed with the essential information, are able to answer questions that otherwise would be referred to a higher administrative authority or a staff department.

4. Department heads can take positive action based on written policy because they know where they stand.

5. The necessity of writing a policy for a manual tends to force a thorough analysis of the subject or problem covered, which results in a more sound policy.

ORGANIZING THE MANUAL

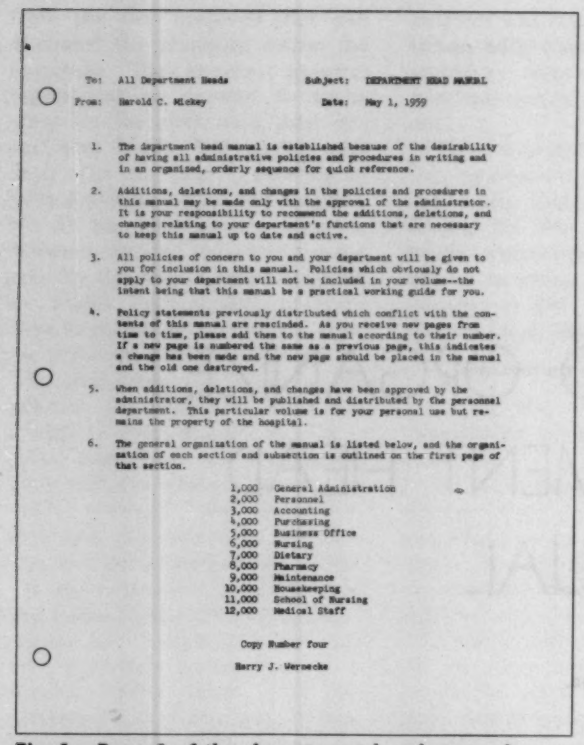
The department head manual should be organized to include all written policies for the entire hospital, even if more than one volume is necessary. Since policies can often be alphabetized under several key words, a numeral organization is preferred over an alphabetical organization of subject matter. A numerical code, on the other hand, can usually be organized around categories which already exist in a hospital organization, such as the various departments.

The manual used at Rochester (Minn.) Methodist Hospital has a major section for each department; that is, for each major area of hospital activity (see Fig. 1). Sections and subsections are organized according to the subject matter of the section (see Figs. 2, 3, and 4).

Following are some suggestions that might prove helpful in building up a department head manual:

1. Use the same format for each page. This should include certain essential information and also in-

Harry J. Wernecke Jr. was personnel director of Rochester (Minn.) Methodist Hospital for five years. He is now a student in the course in hospital administration at the University of Minnesota.



To: All Department Heads Subject: DEPARTMENT HEAD MANUAL
From: Harold C. Mickey Date: May 1, 1959

1. The department head manual is established because of the desirability of having all administrative policies and procedures in writing and in an organized, orderly sequence for quick reference.

2. Additions, deletions, and changes in the policies and procedures in this manual may be made only with the approval of the administrator. It is your responsibility to recommend the additions, deletions, and changes relating to your department's functions that are necessary to keep this manual up to date and active.

3. All policies of concern to you and your department will be given to you for inclusion in this manual. Policies which obviously do not apply to your department will not be included in your volume--the intent being that this manual be a practical working guide for you.

4. Policy statements previously distributed which conflict with the contents of this manual are rescinded. As you receive new pages from time to time, please add them to the manual according to their number. If a new page is numbered the same as a previous page, this indicates a change has been made and the new page should be placed in the manual and the old one destroyed.

5. When additions, deletions, and changes have been approved by the administrator, they will be published and distributed by the personnel department. This particular volume is for your personal use but remains the property of the hospital.

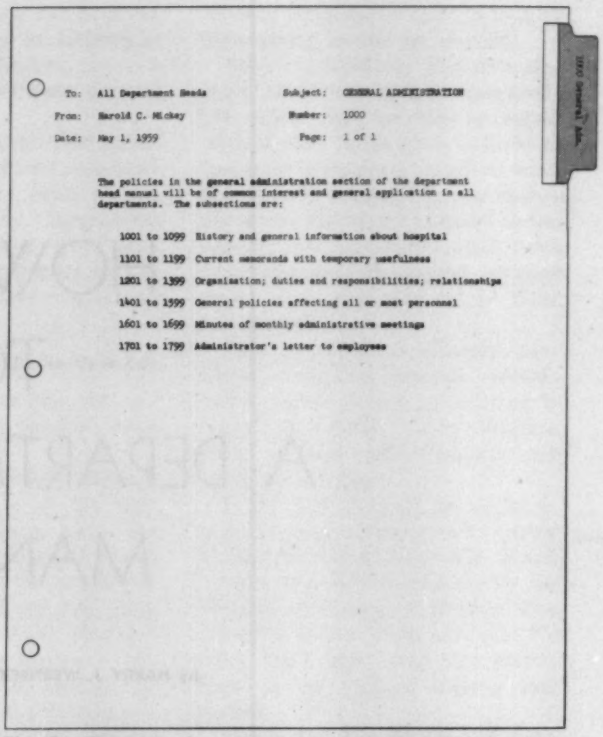
6. The general organization of the manual is listed below, and the organization of each section and subsection is outlined on the first page of that section.

1,000	General Administration
2,000	Personnel
3,000	Accounting
4,000	Purchasing
5,000	Business Office
6,000	Nursing
7,000	Dietary
8,000	Pharmacy
9,000	Maintenance
10,000	Housekeeping
11,000	School of Nursing
12,000	Medical Staff

Copy Number Four

Harry J. Wernecke

Fig. 1—Page 1 of the department head manual



1000 General Adm.

To: All Department Heads Subject: GENERAL ADMINISTRATION
From: Harold C. Mickey Number: 1000
Date: May 1, 1959 Page: 1 of 1

The policies in the general administration section of the department head manual will be of common interest and general application in all departments. The subsections are:

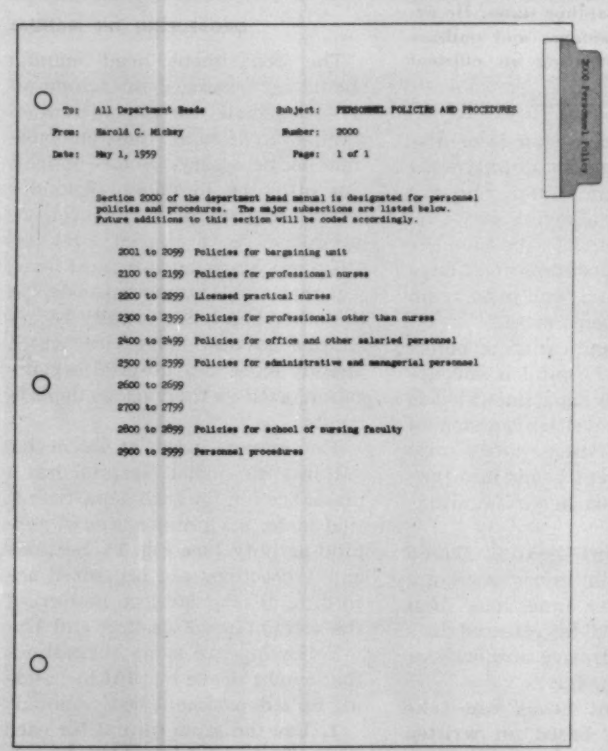
1001 to 1099	History and general information about hospital
1101 to 1199	Current memoranda with temporary usefulness
1201 to 1399	Organization; duties and responsibilities; relationships
1401 to 1599	General policies affecting all or most personnel
1601 to 1699	Minutes of monthly administrative meetings
1701 to 1799	Administrator's letter to employees

Fig. 2—Organization of section on general administration

form the department head of the fact that the page is to be inserted in his manual.

Each page should indicate that it is being sent out by orders of the highest authority concerned with the subject matter, usually the administrator. If the original source

(Continued on page 125)



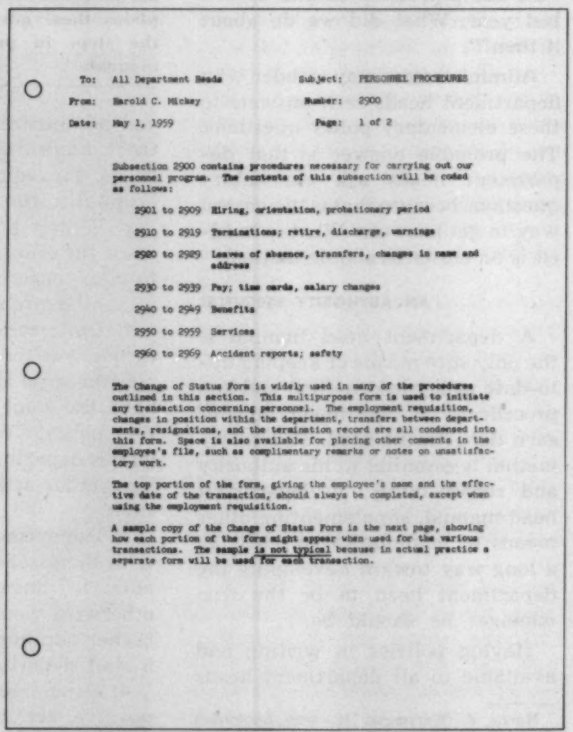
2000 Personnel Policy

To: All Department Heads Subject: PERSONNEL POLICIES AND PROCEDURES
From: Harold C. Mickey Number: 2000
Date: May 1, 1959 Page: 1 of 1

Section 2000 of the department head manual is designated for personnel policies and procedures. The major subsections are listed below. Future additions to this section will be coded accordingly.

2001 to 2099	Policies for bargaining unit
2100 to 2199	Policies for professional nurses
2200 to 2299	Licensed practical nurses
2300 to 2399	Policies for professionals other than nurses
2400 to 2499	Policies for office and other salaried personnel
2500 to 2599	Policies for administrative and managerial personnel
2600 to 2699	
2700 to 2799	
2800 to 2899	Policies for school of nursing faculty
2900 to 2999	Personnel procedures

Fig. 3—Organization of section on personnel policies and procedures



To: All Department Heads Subject: PERSONNEL PROCEDURES
From: Harold C. Mickey Number: 2900
Date: May 1, 1959 Page: 1 of 2

Subsection 2900 contains procedures necessary for carrying out our personnel program. The contents of this subsection will be coded as follows:

2901 to 2909	Hiring, orientation, probationary period
2910 to 2919	Terminations; retire, discharge, warnings
2920 to 2929	Leaves of absence, transfers, changes in name and address
2930 to 2939	Pay; time cards, salary changes
2940 to 2949	Benefits
2950 to 2959	Services
2960 to 2969	Accident reports; safety

The Change of Status Form is widely used in many of the procedures outlined in this section. This multipurpose form is used to initiate any transaction concerning personnel. The employment requisition, changes in position within the department, transfers between departments, resignations, and the termination record are all condensed into this form. Space is also available for placing other comments in the employee's file, such as complimentary remarks or notes on unsatisfactory work.

The top portion of the form, giving the employee's name and the effective date of the transaction, should always be completed, except when using the employment requisition.

A sample copy of the Change of Status Form is the next page, showing how each portion of the form might appear when used for the various transactions. The sample is not typical because in actual practice a separate form will be used for each transaction.

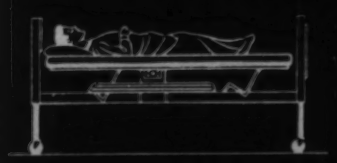
Fig. 4—Organization of subsection on personnel procedures

AMP
ALL-ELECTRIC HOSPITAL BED
the FOREMOST in electric bed design and efficiency

The amp bed is listed by Underwriters' Laboratories, Inc., for use with oxygen administering equipment.

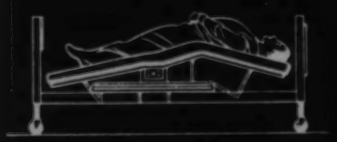
We invite your inquiry

Here are a few of the medical positions provided by the AMP All-Electric Bed

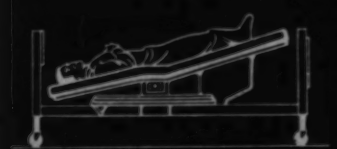


HIGH PRONE POSITION

REVERSE SPINAL POSITION



SPINAL HYPEREXTENSION



TRENDELENBURG POSITION

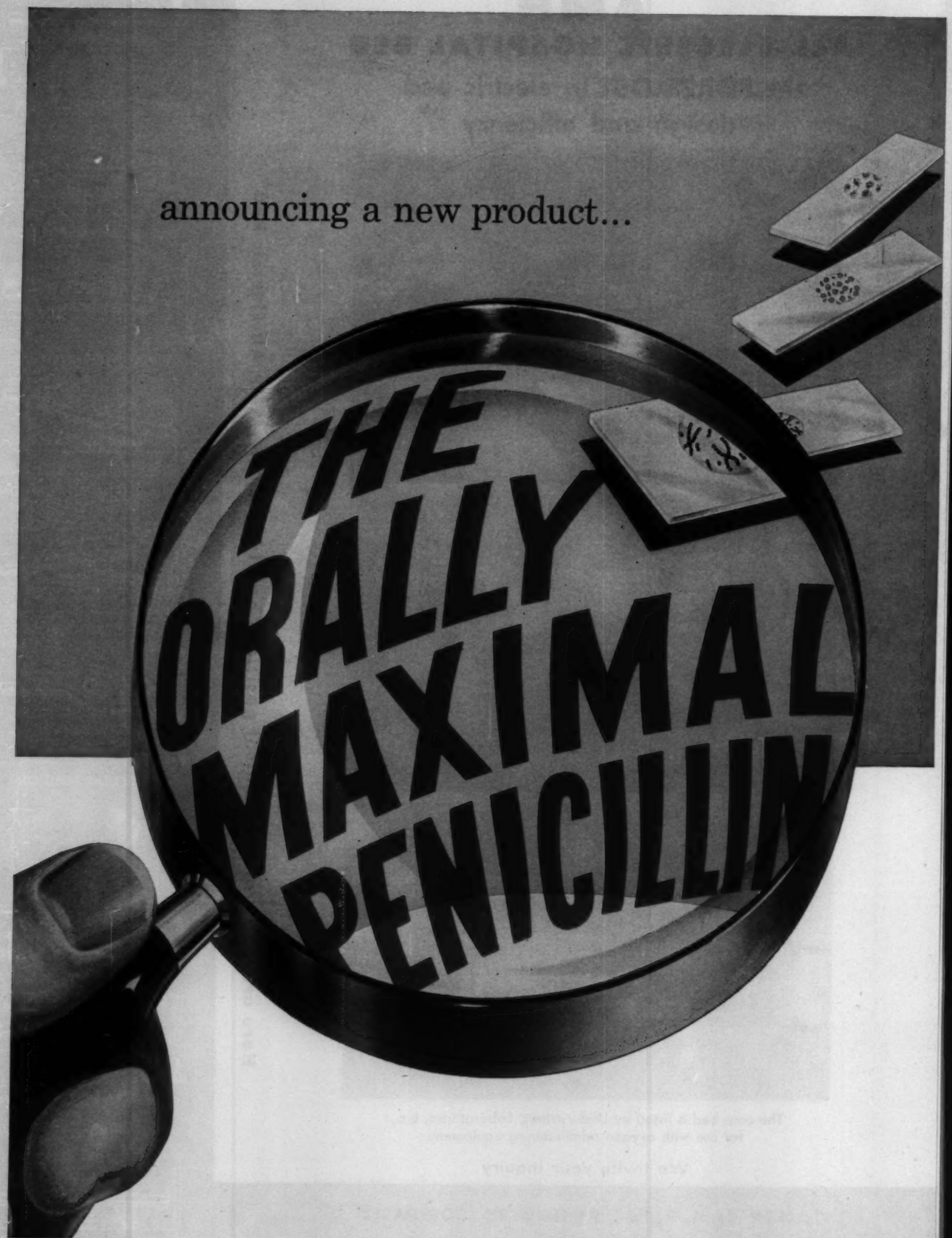
REVERSE TRENDELENBURG (Head Traction) POSITION

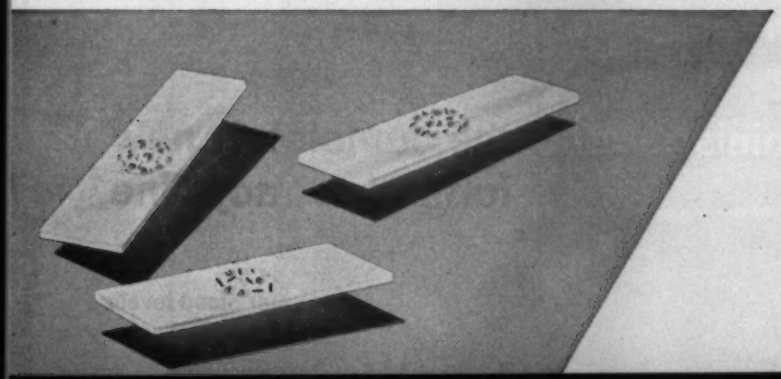
VASCULAR POSITION

HIGH FOWLER POSITION

LOW FOWLER POSITION

EARLY AMBULATION POSITION


announcing a new product...
THE
ORALLY
MAXIMAL
PENICILLIN



MAXIPEN

MAXIMAL ABSORPTION

Acid stable, extremely soluble. MAXIPEN is rapidly absorbed from gastrointestinal tract.

MAXIMAL BLOOD LEVELS

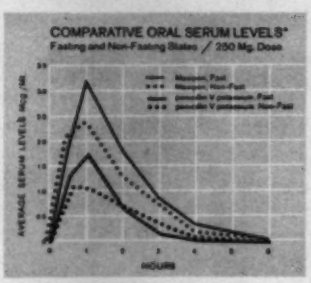
Substantially higher than potassium penicillin V (higher levels than with intramuscular procaine penicillin G). You get injection levels with a tablet.

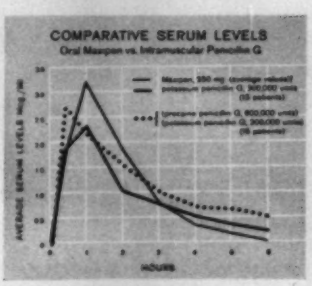
MAXIMAL ORAL INDICATIONS

Indicated in infections caused by streptococci, pneumococci, susceptible staphylococci, and gonococci, including:

- pneumococcal pneumonia
- gonorrhea
- tonsillitis
- laryngitis
- otitis media
- streptococcal pharyngitis
- impetigo
- susceptible staphylococcal abscesses (with indicated surgery)
- cellulitis
- lymphangitis
- pyoderma

Also prophylactically in secondary infections following tonsillectomy, dental extractions, other surgical procedures.





*Based on 3294 individual serum antibiotic determinations.
†Based on 1716 individual serum antibiotic determinations.
Complete details on request.

MAXIMAL FLEXIBILITY

May be administered without regard to meals. However, highest absorption is achieved when taken just before or between meals.

Dosage: For moderately severe conditions, 125 to 250 mg. three times daily. For more severe conditions, 500 mg. as often as every 4 hours around the clock.

Note: To date, MAXIPEN has not shown less allergic reactions than older oral penicillins. Usual precautions regarding penicillin administration should be observed.

Supplied: MAXIPEN TABLETS, scored, 125 mg. (200,000 units) bottles of 36; 250 mg. (400,000 units) bottles of 24 and 100.

MAXIPEN FOR ORAL SOLUTION; reconstituted each 5 cc. contains 125 mg., in 60 cc. bottles.

Triumph of Man Over Molecule

Designed by Pfizer for Maximal Benefit

The high oral efficacy of MAXIPEN is due to the fact that this is a new "tailor made" penicillin—a mixture of the D and L isomers of α-phenoxyethyl penicillin potassium. It is the first available of the penicillins now being designed by the Research Division of Pfizer, pioneer in the commercial development of penicillin and a leading producer for 17 years.

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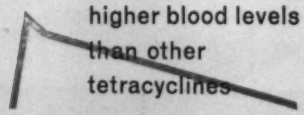
Science for the World's Well-Being ™

for parenteral administration

the completely new form of tetracycline



Velacycline Intramuscular peak blood levels are twice as high as those produced by intramuscular tetracycline phosphate complex, and these blood levels remain consistently higher over a 24-hour period.

more soluble than other tetracyclines

Velacycline is 2500 times more soluble than ordinary tetracycline. Because of the high solubility of Velacycline Intravenous over the entire physiological pH range and its neutral pH in solution, this preparation is unusually well adapted for intravenous therapy.

more efficiently absorbed than other tetracyclines

Velacycline Intramuscular is more readily absorbed than any other form of intramuscularly administered tetracycline, thus providing rapid, peak concentrations of the antibiotic at the site of infection.

Supply: VELACYCLINE INTRAMUSCULAR: Single-dose vials of 150 mg. *or* 350 mg. (for reconstitution). Formulated with Xylocaine and buffered with ascorbic acid. VELACYCLINE INTRAVENOUS: Vials of 700 mg. (for reconstitution). Buffered with ascorbic acid.

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Squibb Quality—
the Priceless Ingredient

VELACYCLINE intramuscular intravenous

Squibb N-(Pyrrolidinomethyl) Tetracycline

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"XYLOCAINE"® IS A TRADEMARK OF ASTRA PHARMACEUTICAL PRODUCTS INC. FOR LIDOCAINE

professional practice

A CRITICAL INCIDENT STUDY OF HOSPITAL MEDICATION ERRORS

(Continued from page 53)

clature. In many cases in which a nurse misread a label, she selected a drug with a name similar to the one ordered. When she made an error in copying the name of the drug ordered by the physician onto the nursing care card and medicine tickets, she often wrote the name of a drug similar to the one ordered. In addition, nurses have reported that they are sometimes confused by the fact that there are many drugs of the same chemical composition, but with different trade names. All of these instances point to the fact that the present system of drug nomenclature is confusing and can stand much improvement. It is recommended, therefore, that the pharmaceutical industry study this problem with the aim of setting up standards for drug nomenclature.

2. *The method of writing drug dosages.* In several instances in which a nurse misread the dose of the drug written on the medication order or the label, she failed to note the decimal point of the dosage. Thus, .1 c.c. was read as 1 c.c., or 2.5 mgm. was read as 25 mgm. In addition, nurses often confused similar abbreviations: for example, micrograms (mcg.) with milligrams (mgm.). This indicates that the present method of writing drug doses can result in perceptual errors, and should be improved. One possible improvement might be to write the drug dose as a fraction to avoid the perceptual errors that occur when decimal points are used.

3. *The standard medical terminology.* Nurses sometimes confused certain standard medical abbreviations. For example, every night (q.n.) was confused with every hour (q.h.), and every other day (q.o.d.) was confused with every day (q.d.). Furthermore, nurses sometimes did not understand the meaning of certain common terminology; for example, the instruction to give the medicine on *odd* or *even* days. This indicates that the medical profession should undertake research to devise a system of terminology that is less confusing.

4. *The visibility of the medication orders.* The medication orders written in the physicians' order book were often not noted, and hence not transcribed to the nursing care cards and medicine tickets. This indicates that the physicians' orders are not presented clearly. It is recommended, therefore, that the nursing department and the medical staff study this problem and devise a way of presenting orders so they can be more readily perceived.

5. *The legibility of drug labels and the arrangement of drugs in the ward medication cabinet.* Other factors that contribute to incidents are the poor labeling of drugs and their arrangement in the ward medication cabinet. Many drug labels were difficult to read under suboptimal conditions. Sometimes this was because information was illegibily written. In other cases, the print of some part of the message was very small, or some part of the message was ambiguous.

The arrangement of drugs in the ward medication cabinet is not standardized and varies greatly throughout the hospital. However, in many of the units visited, the drugs were placed so that it was

difficult to see the label, and to reach the drug. In addition, in a few units, it was found that two drugs that were frequently confused, digoxin and digitoxin, were kept in the same section of a drawer. All of this suggests that drug labels should be designed according to sound human engineering principles and that research should be conducted on the optimal arrangement of drugs in the ward pharmacy. Some concrete suggestions on the latter point have been offered by Archambault.[5]

MEDICATION PROCEDURES

A large number of incidents occurred because nurses made errors while following procedures, or failing to follow procedures. This suggests that the medication procedures need to be studied from two viewpoints: (1) That of singling out any difficulties associated with particular procedures, and then making the necessary changes so that they are easier to follow, and (2) that of building more safety checks into medication procedures, so that if a nurse should forget to follow one step, or makes an error, it would be detected at some other step.

To illustrate the first point:

a. In a substantial number of incidents, the nurse forgot to follow the procedure of checking the bedside tag against the medicine ticket. This suggested that the bedside tag should be carefully studied. Subsequent investigation showed that the bedside tag is neither easily visible nor accessible. The tag is small, the information on it is handwritten and it is placed low on the foot of the bed. The following changes would make it easier to identify patients:

(1) The appearance and location of the bedside tag should be modified so that it is more easily visible and more accessible.

(2) Nurses should be required to check the medicine ticket against the patient's wristband (a recent innovation in the study hospital).

b. Nurses' errors in calculating the amount of the drug to be poured for the ordered dose of medicine suggests that the doses or units in which medicines are ordered should be made consistent with the doses in which they are packaged. Many drugs are packaged in one unit, that is, grams, but ordered in milligrams; or labeled in milligrams, but ordered in micrograms. This may be confusing to the nurse, and involves extra calculations on her part. This suggests the following recommendation: There should be closer correspondence between the units or doses in which drugs are ordered and those in which they are packaged.

With regard to the point under (2) above, the following recommendations are offered:

(a) Someone other than the nurse in charge should check the orders written in the physicians' order book against the nursing care cards and medicine tickets to which they have been copied. Then, even if the nurse in charge did not pick up a transcription error, the other person might.

(b) The nurse assigned to give medicines should make some mark on the nursing care cards indicating the medicines she is going to pour when she leaves to pour them. Then, if she should forget to sign an order off, when she intended to give the medicines, she could check to find out if she had. This might avoid some of the errors in which a patient receives an extra, unordered dose of medicine.

(c) More safety checks and redundancy should be built into medication procedures so that if a nurse should forget to follow one step or make an error it would be caught by some other step. One way of building such additional redundancy into medication procedures is to provide the patient himself with a little more information about the medication he is scheduled to receive. Being vitally concerned with his own health and safety, he would thus become an active and interested partner in elminating certain kinds of common errors. The patient who knows, for example, that he is supposed to receive two blue pills every four hours (even though he may not know what they are supposed to do) will almost certainly object if a nurse attempts to give him an intramuscular injection, if he is offered two yellow pills, or if he is given two blue pills only fifteen minutes after having already swallowed two.

THE GENERAL WORKING ENVIRONMENT

Many nurses indicated on the questionnaire that they were distracted and interrupted in their work. This suggests that the environment in which medication orders are processed and carried out be carefully studied and modified so that the nurse can work under more nearly optimal conditions. Some improvements might be to:

1. Locate the nurses' station and ward medication cabinet where there is a small flow of traffic.
2. Schedule administration of medicines so that a heavy load of medication is not given when the ward is a hub of activity.
3. Assign special nurses to carry out unscheduled medication orders.
4. Alert the physicians and nurses to the need for not interrupting a nurse, unless absolutely necessary, when she is carrying out medication orders.
5. Give the nurse more adequate work space, especially in the area where medicines are poured, so that one nurse is not constantly rubbing shoulders with another.

TRAINING AND EDUCATION

Suggestions have been offered as to ways of alleviating many of the problems of the medication system by modifying the written communication, the general working environment and some procedures. In addition, the improvement of the system requires that nursing personnel be well trained in medication procedures, be alerted to the hazards of their work and be highly motivated to avoid error. This responsibility rests with the instructional staff of the hospital, the instructors in the classroom and the head nurses on the wards.

The data that have been presented have pointed up the problem areas of the system. It is known what kinds of errors nurses make and what some of the casual factors are. It is recommended, therefore, that this information be used by the instructional staff in training nursing personnel.

Specifically, while instructing nurses in the medication procedures, the instructors should:

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TRADITIONAL SUPERIORITY

CONTEMPORARY CONVENIENCE

The traditionally sharper carbon steel B-P RIB-BACK Blades in the contemporary sterile packages, designed for time-saving convenience. Individual unopened packages are ready for autoclaving—if desired.

The uniformity with which these individual, puncture-resistant, reinforced foil packages can be opened is a further safeguard of blade sterility.

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B-P RIB-BACK Blades are also available: RACK-PACK packages or 6 Blades of a size in rust-resistant wrappers.

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1. Single out the casual factors associated with medication incidents; for example, failure to follow the checking procedures or misreading or misinterpreting written communication.

2. Single out some examples of written communication that may result in perceptual error; for example, drugs with similar names, similar abbreviations, poorly labeled drugs, and so forth.

3. Emphasize the fact that because written communication is poor, the environment is not optimal and the work load is heavy, it is only by checking constantly that the nurse can avoid error.

FOLLOWUP

Although the primary purpose of this study was to discover sources of error in medication procedures and to make recommendations for the improvement of the medication system, it may be of interest to note what followup has been made on these recommendations. Recommendations often die unless there is an individual or a group who has the initiative, authority and interest to carry them out.

In the case of the hospital studied here, there were, fortunately, two such groups. One of these was the operations research division which is responsible for studying administration procedures and for bringing the resultant recommendations to the attention of the appropriate authorities. The other group was the safety committee composed of a team of specialists selected from hospital administration and charged with the responsibility of carrying out changes which will improve hospital operation and practice.

This program follows the general precedent set by operations research groups in industry. The OR group normally occupies a staff position and in this position it is able not only to conduct studies but also to provide a facility through which recommendations can be pursued. This in itself constitutes an interesting experiment in hospital administration, the ultimate success of which is yet to be determined.

A special questionnaire was prepared to collect medication error and near error incidents from the nursing personnel of the Johns Hopkins Hospital. Over a period of seven months, 178 incidents were obtained.

1. The 178 incidents could be classified into the following seven types with the frequencies shown:

a. The *wrong patient* received or almost received a medicine. 36

b. A patient received or almost received the *wrong dose.* 36

c. A patient received or almost received an *extra* (unordered) dose of medicine. 36

d. A patient's medicine was *omitted* or almost omitted. 31

e. A patient received or almost received the *wrong* drug. 23

f. A patient received or almost received a medicine at the wrong time. 14

g. A patient received or almost received a medicine through an *improper route.* 2

2. An analysis of the immediate causes for the incidents of each type shows that: (a) only a few causes will account for the majority of the incidents of each type; (b) certain causes are specific to a given class of incidents, and (c) other causes will precipitate several different types of incidents.

3. An analysis by underlying cause without regard to type of incident shows that five categories account for 90 per cent of the incidents. The most important of these are: (a) failure to follow required checking procedures; (b) misreading or misunderstanding written communication, and (c) calculational errors.

4. An analysis of incidents by the *job classification* of the respondent and *service* where the incident occurred shows that: (a) most of the incidents were reported by student nurses and (b) most incidents occurred in four of the eight services of the hospital where the medication load is very heavy or the patients are difficult to handle. The data suggests that the medication load and the stresses of a particular service are more important factors than job classification in precipitating medication errors.

5. The frequency of incidents reported varies markedly with the time of day. These variations in frequency may be explained by one or more of the following: (a) preferred times for scheduling medicines, (b) stress periods correlated with certain times of day, (c) meal hours, and (d) change of shift.

6. Many incidents occurred when a nurse had to administer medication to a single patient only. These incidents appear to stem from the fact that such assignments are almost always unscheduled and so interrupt the nurse in her routine.

7. Recommendations have been made with respect to four areas: (a) written communication, (b) medication procedures, (c) the general working environment, and (d) training and education. ■

The Mentally Ill Can Come Back!

In the past 25 years, science has wiped out one dread disease after another. With polio just about conquered, science can now turn its attention to our #1 health problem—mental illness.

Already medical science has begun to find the way to treat mentally sick people and to get them well again.

But it takes the unbeatable team of more research, treatment, prevention, and YOU to keep them well and to help ALL the mentally ill recover.

You can do your part. Support your mental health association.

NATIONAL ASSOCIATION FOR MENTAL HEALTH

SUPPORT YOUR MENTAL HEALTH ASSOCIATION

REFERENCES

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There IS a difference in the quality of

SURGICAL DRESSINGS

"Some time ago we were asked to make tests of surgical dressings. Frankly I was doubtful that there could be much difference, especially in the standard dressings we use in tremendous volume, such as, sponges, pads, cotton balls, and so on.

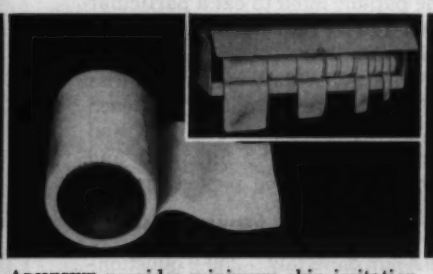
My choice after the tests was MARCO — they were *better* than any used previously. This was borne out by the staff's remarks about higher absorbency and softness, and uniformity of sizes and folds.

Besides, we also found the Marco people to be very resourceful in developing new dressings and in improving the quality and usefulness of old ones."

OPAKE SPONGES highly X-ray detectable element is spread throughout sponge. Non-traumatic to tissue. Bulk or pre-counted in 10's, 3" x 3" to 8" x 4"

LAPAROTOMY TAPE PADS X-ray detectable, permanently bonded tape to attach to ring or hemostat. Quilted to hold shape, withstand repeated laundering. 12" x 12" or 18" x 18" square—18" x 4" or 36" x 8" oblong.

READY-CUT BANDAGE ROLLS sealed edges prevent thread ravelling. Flip-up flap on wrapper permits one-hand removal, controls unrolling—selfsealing to keep bandage clean. 10 yards long—all widths.



ADHESIVE provides minimum skin irritation, minimum creep, no impurities. Firm fabric for wrinkle-free application, effective support. Adheres with normal hand pressure. 10 yards —½" to 4".

COTTON BALLS soft and firm, made of long-staple white absorbent cotton. Useful for perineal care, for prepping, as wipes and swabs (not sterilized). Five sizes—⅝" to 2".

TWINPAKT DRESSINGS for post-operative work, saves valuable time, minimizes waste and are guaranteed sterile.

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FOOD PREFERENCE SURVEY

guide to better menus

by ELIZABETH McCUNE

BEFORE new menu items are added to patient and personnel menus at the University of Kansas Medical Center, Kansas City, Kans., a tasting table is set up in the personnel cafeteria. Staff and personnel are invited to sample the proposed menu item and to record their comments. Here tuna pizza is being sampled.

The author reports that after questionnaires were sent to patients and personnel at the University of Kansas Medical Center, Kansas City, Kans., to determine their food preferences, the hospital's selective cycle menus were rewritten in accordance with survey findings. The end results were better menus, lower food costs through reduced plate waste and increased satisfaction with patient and personnel food service.

IN MOST aspects of medical care, the patient readily accepts the judgment of experts. The surgeon's advice for treatment is usually followed without question. Medication by mouth or injection may be considered an unpleasant routine but is accepted by the patient with little or no protest.

The acceptance of food on the hospital tray, however, is quite another matter. On this subject, the patient considers himself the expert.

Most often the patient's evaluation of hospital food is made confidently on the basis of "I know what I like". His reasons for acceptance or rejection may or not be logical. Whatever the reason given for certain food preferences, it must be noted that food acceptance is important to the patient's feeling of security as well as to the treatment of his illness.

Hospital administrators expect members of the medical team to accept the patient in relation to his family setting. At the University of Kansas Medical Center, Kansas City, this fact challenged the dietitian to devise a feasible method of determining patient food acceptance and, in light of the results, to reevaluate the foods served. To achieve these goals, a food preference survey was conducted at the center in 1959.

Elizabeth McCune is assistant director, department of dietetics and nutrition, University of Kansas Medical Center, Kansas City, Kans.

OBJECTIVES OF SURVEY

The following objectives were established for the project:

1. *To increase patient satisfaction.* It was thought that use of menu items acceptable to the greatest number of patients and elimination of disliked foods would increase patient satisfaction.

2. *To decrease the number of items prepared.* Offering fewer food items should allow for better standardization of recipes, ordering procedures, transportation methods and employee training. There should also be a reduction in the number of orders for special foods which had always occurred when unpopular items appeared on the menu. By preparing a smaller number of items, it was also felt that they would meet higher standards.

3. *To reduce waste.*

To attain these objectives, it was necessary to find out what people wanted to eat. This was accomplished by sending a questionnaire to patients. Approximately 200 items, including all types of food generally served at the hospital, were listed on the questionnaire. The survey also indicated whether the patient liked to eat a particular food often, occasionally or never. (See Fig. 1, p. 72).

On a given day, a dietitian distributed questionnaires to each patient, explained to him how and when it was to be filled out and when it would be picked up.

RESULTS OF SURVEY

Approximately 350 questionnaires were completed. The results were then tallied by clerical employees and analyzed by a statistician. The results indicated four categories of foods—those to be used daily, those to be used twice weekly, those to be used once weekly, and those that were to

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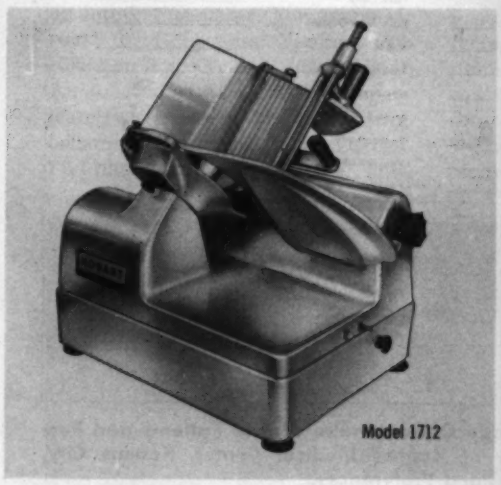

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UNIVERSITY OF KANSAS MEDICAL CENTER
DIETETICS AND NUTRITION DEPARTMENT

FOOD PREFERENCE SURVEY

Please check (✓) in space that describes your taste.

I like the following –

	Often	Occasionally	Never
Soup			
Vegetable Soup			
Chicken Soup			
Navy Bean Soup			
Cream Soups			
Split Pea Soup			
Potato Soup			
Tomato Soup			
Onion Soup			
Juices			
Orange Juice			
Tomato Juice			
Grapefruit			
Pineapple Juice			
Sandwiches			
Roast Beef Sandwich			
Roast Pork Sandwich			
Baked Ham Sandwich			
Cheese Sandwich			
Luncheon Meat Sandwich			
Peanut Butter Sandwich			
Egg Salad Sandwich			
Tunafish Salad Sandwich			
Salmon Salad Sandwich			
Meat and Meat Dishes			
Ground Beef Dishes			
Barbecued Spareribs			
Beef Stew Dishes			
Roast Beef			

	Often	Occasionally	Never
Meat and Meat Dishes (Cont)			
Frankfurters			
Chili			
Chipped Beef Dishes			
Chop Suey			
Corned Beef			
Ham Loaf			
Ham Balls			
Ham Dishes			
Baked Ham			
Ground Lamb Dishes			
Lamb Stew Meat Dishes			
Roast Lamb			
Liver			
Beef Shortribs			
Pork Chop			
Pork Stew Dishes			
Roast Pork			
Smothered Steak			
Meat and Spaghetti			
Stuffed Pepper			
Sweetbreads			
Veal Roast			
Veal Stew Meat Dishes			
Veal Birds			
Veal Cutlet			
Poultry Dishes			
Creamed Chicken			
Chicken Croquette			
Chicken & Dumplings			

Fig. 1—Page One of Four-Page Questionnaire Sent to Patients and Personnel at University of Kansas Medical Center, Kansas City, Kans., To Determine Food Preferences.

be omitted from selective menus.

Foods to be served daily. The only food items popular enough to be used daily were orange juice, peaches and potatoes (potatoes were desired twice a day).

Foods to be served semi-weekly. The items to be used twice each week included tomato juice, pineapple juice, roast beef, baked ham, pork chops, spaghetti and meat balls, fried fish, beets, green beans, tomatoes, cottage cheese, jellied fruit salad, apples, pears, grapes, cantaloupe, baked custard, gelatin and ice cream. A few of these items, such as roast beef and fried chicken, could be served as often as three times each week.

Foods desired once a week. Foods that were popular enough to be used on the menu once a week included vegetable soup, grapefruit juice, beef stew, chili, liver, roast pork, macaroni and cheese, cabbage, carrots, spinach, broccoli, greens, tomato salad, red cherries, watermelon, berry pie, pecan pie, butterscotch pie, and custard pudding.

Foods to be avoided. The foods to be completely omitted from patients' menus included cream soups (excluding tomato and potato), ground lamb, pork stew; sweetbreads, codfish, crab meat, lobster, cheese fondue, creamed fish and eggs, rarebit, summer squash, acorn squash, parsnips, rutabagas, okra, and tomato aspic salad.

The results of the survey were then used to rewrite the menus for all patient food services. A committee, including the director of the department, her assistant, two food production dietitians and one floor service dietitian, was responsible for the menu writing. The assistance of the dietitians in therapeutics, pediatrics and modified diets was sought when their areas were being considered.

A five-week selective cycle menu was written. The committee agreed to use the survey results in selecting all menu items to be included. The selective menu for the normal diet was the first one written and all other menus were written as modifications of the normal diet.

After the normal, soft, bland, full liquid and other modified diets had been completed, the menus were reviewed to give each item an interesting name. For example, roast beef became Yankee Pot Roast or Roast Loin Points of Beef Au Jus; baked hash became American Baked Hash; bread pudding became Country Kitchen Bread Pudding with Lemon Sauce. This action brought about the need for a glossary which could be used as a guide in interpreting the menu items. A glossary of the menu items and the ingredients of each was then developed (Fig. 2, p. 74). This glossary is an invaluable tool to the therapeutic dietitian in planning modified diets.

DETERMINING ACCEPTANCE

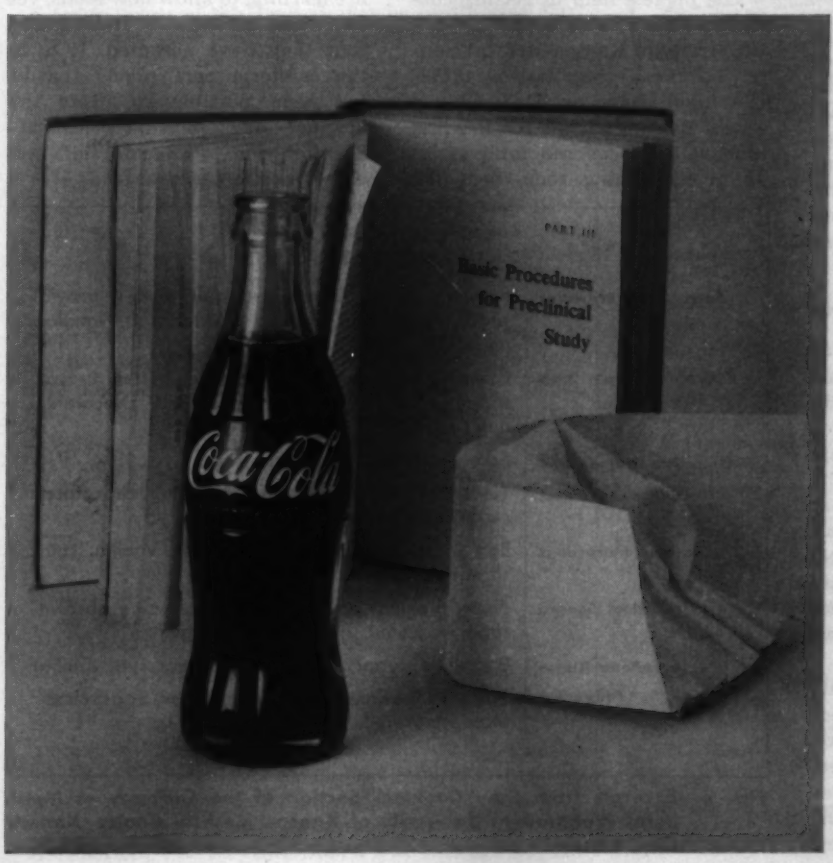
The final step in the original project was the serving of a new set of menu items and an evaluation of the attainment of the study's objectives. Evaluation of patient satisfaction was made by a personal visit to each patient by the therapeutic dietitian. Patients (excluding pediatric patients) whose average length of stay was eight days said that the menus were very good. However, the long-term patient in the tuberculosis and psychiatric units preferred more variety in the menu items served. They grew tired of roast beef, ham, and spaghetti and meat balls twice each week.

The survey and revision of menus resulted in fewer items to prepare and fewer special orders. Plate waste was decreased.

Dietitians found it difficult to accept the patient's selection. For example, when chicken and noodles appeared as an entree, they were distressed to see the patient select potato as the vegetable accompaniment, or cauliflower with spaghetti. The appearance of food combinations on the plate rather than lack of nutrients, however, were usually the cause of the dietitian's distress.

Since the first five-week cycle menu for summer was completed, a second five-week cycle for winter has been written. These sets of menus have been used approximately 18 months without change. Recently, a daily review was being made of each menu item served. As a result only very minor adjustments were made, and these were primarily concerned with meat selection on the bland diet.

A study of acceptance of breakfast foods by the pediatric patients was conducted by a dietetic intern. This study served as a basis for rewriting menus for that unit. A



When too many tasks
seem to crowd
the unyielding hours,
a welcome
"pause that refreshes"
with ice-cold Coca-Cola
often puts things
into manageable order.

DRINK
Coca-Cola

questionnaire and a study of food intake was used to obtain the necessary data. Fruits to be included were orange juice, orange sections, grapefruit half, banana half sliced on cereal, pineapple juice, grapefruit juice, grape juice and apple juice.

Fruits to be used not more than every 10 days were tomato juice, apricot nectar and grapefruit sections. Stewed prunes were to be omitted.

The most accepted form for service of eggs was hard-cooked. Soft-cooked and scrambled eggs were not to be used more than once a week. Poached eggs would be omitted. Sausage patties and Canadian bacon strips should not be used more than once a week.

Jelly was to be offered with all bread items, including buttered white toast, white bread and whole-wheat bread. Buttered whole-wheat toast was not to be used more than once a week. French toast was more popular when served in one-half slice portions. Sweet rolls were not popular enough to be used more than once a week.

Cooked cereal was unpopular and, therefore, was to be used only occasionally. Dry cereals to be used included rice krispies, kix, sugar crisps, grapenut flakes, cornflakes, grapenuts, pep and wheaties. Puffed wheat, puffed rice and shredded wheat cereals would not be used more than once every 10 days.

SURVEY OF PERSONNEL

A food preference survey similar to the one conducted for patients was done in the cafeteria. All staff, employees and students, both professional and nonprofessional, eat in the pay cafeteria. In general, the same pattern of acceptance was found there as in the patient areas. Many additional comments, however, were received, such as undercooking of vegetables, preference for canned rather than frozen peas, potatoes every meal, etc.

The cafeteria menu is also written as a modification of the selective menu for the normal diet. Since a greater selection is offered, some items are used in the cafeteria that never appear on the patients' menu. After the new menus were offered in the cafeteria, more compliments were received on the cafeteria food service. However, there was a change in the number of items sold. For example, when chili appeared more frequently on the menu, a fewer number of orders were served.

While the emphasis of this project was to determine food acceptance and to write menus that would include acceptable items, attention was also focused on the dietitian's responsibility for re-education. It is not enough to try to please everyone by offering foods that they already know. While the patient is more comfortable with familiar foods, the staff and employees who eat in the cafeteria year after year offer the dietitian an opportunity to teach them to try and like things that they have never tried before. Since staff and employees probably feel that they are experts on foods that they like, it may take some ingenuity on the part of the dietitian to get them to try what she believes would be a popular addition to the menu.

The biggest help in getting customers to try "a new dish" at the University of Kansas Medical Center has been the "tasting table" (See photograph on p. 70). When a new food is offered for the first time, a linen-covered table is set up in the dining room near the traffic aisle and each customer is invited to "taste" the food and record their reaction to it on a card. They are asked: Does it taste good? Does it look good? What would you like to have it served with?

When the "tasting table" first appeared, the attendant had to work hard to get nurses, physicians and other staff and personnel to taste a sample, but now they stop to ask "What's new today?" On the basis of acceptance at this tasting table, the new food item is added or deleted from the permanent file and the regularly scheduled menu.

The decoration of the table is simple but attractive, and generally is in keeping with the food item. When the food to be tasted was tuna souffle and sardinia eggs, decorations included goldfish bowls, shells and rocks.

EVALUATION OF STUDIES

The dietitians at the University of Kansas Medical Center believe that these studies have been a valuable experiment. The customers are learning to know new foods, yet the menu offers only those items that they have accepted. It is in the cafeteria particularly that it has been possible to attain the original objective of increased satisfaction and to educate staff and employees to eat new foods. ■

COOKIES

Butterscotch Brownies	Formerly called Blonde Brownies, butter, brown sugar, eggs, flour, baking powder, salt, vanilla, nuts
Chocolate Cream Drop	Formerly Chocolate Drop Cookie, butter, brown sugar, eggs, milk, flour, soda, salt, chocolate, nuts, vanilla
Chocolate Nut Cookie	Same as Chocolate Cream Drop
Chocolate Pixies	Flour, baking powder, salt, shortening, chocolate, sugar, eggs
Coconut Macaroons	Egg white, sugar, powdered sugar, vanilla, salt, shredded coconut
Coconut Square	Flour, baking powder, salt, shortening, brown sugar, coconut, nuts, vanilla, eggs
Cornflake Kisses	Egg white, sugar, cornflakes, nuts, coconut, vanilla
Fudge Bar	Same as Brownies, shortening, sugar, eggs, chocolate, flour, milk, pecans, salt, vanilla

Fig. 2—Excerpts from the "Cookies" Section of the Glossary of Menu Items Prepared at University of Kansas Medical Center, Kansas City, Kans.

Summer Cycle Menu for the South-Southwest

THE 21-DAY selective summer cycle menu and market orders for perishables are designed for hospitals in the North-Northwest. These menus, which are to be used during June, July and August, feature foods popular in the northern and northwestern parts of the country.

The menus in this issue are the final set in a four-part series of summer cycle menus published in this Journal. Summer cycle menus for the Midwest were included in the April 1 issue of **HOSPITALS**, J.A.H.A. The South-Southwest summer cycle menus were published in the April 16 issue of the Journal. The East menus were included in the May 1 issue.

In planning the menus, careful consideration has been given to keeping the menu and food production operation simple for the smaller hospital. Moreover, a moderate to low cost food budget was used.

This cycle menu features a choice of entree, vegetable, salad and dessert on the noon and night menus. Two cereals and two fruits are offered on the breakfast menu.

Since one of the choices offered is designed for use on modified diets, these menus can be used for both normal and modified diets. The letter (F) following certain items on the menu indicates that this item is to be served on the full or normal diets, while those labeled (S) are for the soft and other modified diets. Where the letters (FS) appear, the menu item can be served on both the full and soft diets.

The spring cycle menus, published in the January and February issues of this Journal, may be used during May. The Midwest and South-Southwest cycle menus were included in the January 1 and 16 issues, respectively. The February 1 and 16 issues featured cycle menus for the East and North-Northwest, respectively.

The market order for perishables, which accompanies each week's menu, lists the meats, seafood, poultry, and fresh and frozen fruits and vegetables that a 50-bed hospital will need to produce the menu. The amounts are computed on the basis of serving 100 patient and personnel meals at breakfast, 125 at noon and 100 at night. By using a multiple of 50, larger hospitals can easily arrive at their market orders.

The market order includes all portion-ready meats, oven-ready roasts, portion-ready seafood, eviscerated poultry and other pre-prepared items.

An added feature of this menu service is the standard storeroom inventory, a list of supplies that a 50-bed hospital should have in the storeroom at the beginning of each 21-day cycle. The items included are cereals and farinaceous products, canned fish, canned fruits and fruit juices, dried fruits and vegetables, jellies, cake and pudding mixes, pickles, canned soups and canned vegetables.

The standard is available upon request from the Association, 840 N. Lake Shore Dr., Chicago 11, Ill.

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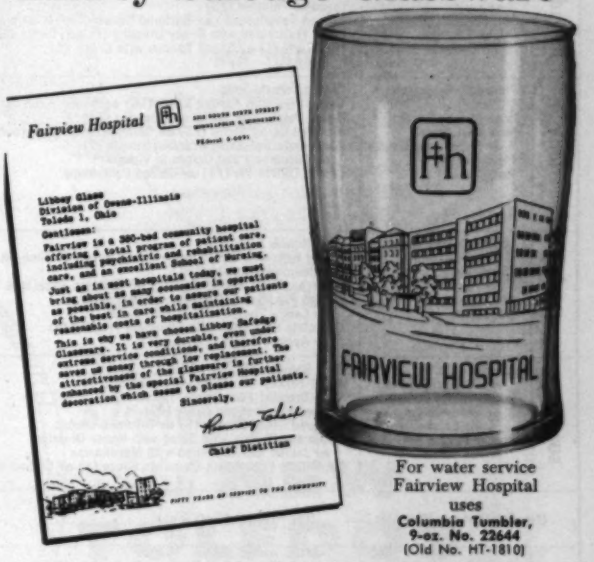

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1st WEEK NORTH-NORTHWEST SUMMER SELECTIVE CYCLE MENU

(MENUS TO BE USED DURING JUNE, JULY AND AUGUST)

—prepared by Virginia Reid, administrative dietitian, St. John's Hospital, St. Paul, Minn.

	breakfast	noon	night
monday	Sliced Fresh Peaches (F) **or** Orange Juice (S) Whole-wheat Cereal **or** Sugar-coated Flake Cereal Soft-cooked Egg Cinnamon Toast	Chilled Tomato Juice Pot Roast of Beef—Vegetable Gravy (FS) **or** Liver with Bacon Strips Buttered Mashed Potatoes (FS) Buttered Mixed Vegetables (F) **or** Escalloped Tomatoes (S) Fresh Fruit Salad with Sweet Dressing (F) **or** Head Lettuce Wedge with Mayonnaise Poppyseed Cake with Boiled Icing (F) **or** Blue Plum Sauce with Sugar Cookie (S)	Cream of Celery Soup Italian Spaghetti with Meat Sauce and Parmesan Cheese (F) **or** Broiled Beef Patty with Catsup (S) Buttered Baked Potato (S) Buttered Peas (FS) **or** Cream Style Corn Orange and Grapefruit Salad with Honey Dressing **or** Sliced Tomato Salad with French Dressing Tapioca Pudding (FS) **or** Mixed Canned Fruit Compote
tuesday	Honeydew Melon (F) **or** Blended Fruit Juice (S) Ready-to-Eat Malt Flake Cereal **or** Chocolate-flavored Wheat Cereal Poached Eggs— Bacon Strips	Chilled Pineapple Juice Roast Leg of Veal—Apple Jelly (FS) **or** Frankfurters—Mustard Escalloped Potatoes (FS) Buttered Green Beans (FS) **or** Buttered Cauliflower Cole Slaw **or** Jellied Cherry-Nut Salad with Mayonnaise (F) Strawberry Shortcake with Whipped Cream (F) **or** Bread Pudding with Lemon Sauce (S)	Consomme Beef Stew with Peas and Carrots (F) **or** Omelet with Mushroom Sauce (S) Parsleyed Boiled Potato (FS) Buttered Summer Squash (FS) **or** Buttered Wax Beans Prune Salad Stuffed with Cream Cheese and Nuts (F) **or** Tossed Salad with French Dressing Vanilla Bavarian Cream (FS) **or** Fudge Square with Chocolate Frosting
wednesday	Tomato Juice (S) **or** Half Grapefruit (F) Oatmeal **or** Puffed Wheat Cereal Scrambled Egg Sweet Roll	Chicken-Rice Soup Stuffed Baked Pork Chop—Applesauce (F) **or** Broiled Lamb Patties—Mint Sauce (S) Buttered Mashed Potatoes (S) Buttered Spinach with Lemon Wedge (FS) **or** Buttered Cabbage with Chopped Olives Shredded Carrot and Green Pepper Salad with Mayonnaise **or** Fresh Melon Ball Salad with Honey Dressing Butterscotch Marble Ice Cream (F) **or** Royal Anne Cherries in Syrup (S)	Cranberry Juice Turkey Pot Pie with Biscuit Topping (FS) **or** Broiled Ham Slice with Raisin Sauce Baked Sweet Potato (FS) Buttered Asparagus Spears (FS) **or** Buttered Peas in Cream Sauce Relish Plate (Radishes, Pickle Slices and Celery Sticks) **or** Frozen Fruit Salad Fresh Peach Cobbler with Nutmeg Sauce (F) **or** Custard with Caramel Sauce (S)
thursday	Fresh Strawberries (F) **or** Apricot Nectar (S) Ready-to-Eat Rice Cereal **or** Farina Soft-cooked Eggs— Link Sausages	Apple Juice Roast Sirloin of Beef (FS)—Gravy—Dill Pickle Slices **or** Spanish Rice with Bacon Creamed Potatoes (FS) Stewed Tomatoes (F) **or** Buttered Squash Topped with Marshmallows (S) Fresh Fruit Salad with Honey Dressing (F) **or** Pickled Beet Salad Date Torte (F) **or** Sliced Banana with Cream (S)	Barley Soup Broiled Hamburger on Bun (FS)—French Fried Onions—Catsup **or** Ham Loaf with Creamy Horseradish Sauce Hash Brown Potatoes (F) Buttered Wax Beans (FS) **or** Creamed Celery with Pimento Cabbage and Banana Salad **or** Pear Half with Cottage Cheese Butterscotch Squares (F) **or** Fresh Cinnamon Applesauce (S)
friday	Pineapple-Grapefruit Juice **or** Stewed Prunes Malt Meal Cereal **or** Puffed Rice Cereal Poached Egg Raisin Toast	Chilled Tomato Juice Baked Pike with Tartare Sauce (FS) **or** Baked Swiss Steak Baked Potato with Butter and Paprika (FS) Buttered Carrot Strips (FS) **or** Buttered Brussels Sprouts Apple-Date-Nut Salad with Mayonnaise (F) **or** Cucumbers and Onions in Vineger Lemon Chiffon Pie (FS) **or** Chilled Cantaloupe	Cream of Potato and Onion Soup Tuna-Noodle Casserole with Cheese Sauce (FS) **or** Fresh Fruit Plate with Cottage Cheese, American Cheese, Pickles, Relishes, Hot Rolls Buttered New Beets **or** Buttered Peas (FS) Tomato Slices with Hard-Cooked Egg Slice and Green Pepper—French Dressing **or** Orange Slices with Coconut Fresh Bing Cherries with Sugar Cookie **or** Blueberry Cottage Pudding with Vanilla Sauce (FS)
saturday	Chilled Orange Juice **or** Half Grapefruit (F) Cornflakes **or** Farina Soft-cooked Egg Sweet Roll	Beef-Noodle Soup Baked Ham with Sweet Sauce (F) **or** Baked Chicken—Spiced Apple (S) Candied Sweet Potato (FS) Buttered Whole Kernel Corn (F) **or** Buttered Asparagus Tips (S) Minted Pear Salad with Honey Dressing **or** Celery Stuffed with Peanut Butter Chocolate Chip Cake with Chocolate Frosting (F) **or** Apricot Halves in Syrup (S)	Chilled Apricot Juice Baked Veal Cutlet with Mushrooms (FS) **or** Pork Patty with Applesauce French Fried Potato Buttered Green Beans (FS) **or** Cauliflower Au Gratin Chef Salad with French Dressing **or** Banana-Nut Salad with Mayonnaise (F) Fresh Strawberries (F) **or** Lemon Sherbet (S)
sunday	Stewed Apricots **or** Grapefruit Juice Rolled Wheat Cereal **or** Ready-to-Eat Malt Flake Cereal Poached Egg— Grilled Ham	Beef Bouillon Roast Turkey—Dressing—Cranberries (FS) **or** Breaded Pork Chop—Spiced Peach Mashed Potatoes and Gravy (FS) Buttered Green Beans (FS) **or** Creamed Onions Apple and Orange Slice Salad with Honey Dressing **or** Jellied Mexican Salad with Mayonnaise Vanilla Ice Cream with Chocolate Sauce (S) **or** Chilled Watermelon (F)	Cream of Chicken Soup Meat Loaf with Tomato Sauce (FS) **or** Hot Potato Salad with Wieners French Fried Potatoes (F) Buttered Spinach with Chopped Eggs (FS) **or** Buttered Broccoli Jellied Fresh Fruit Salad with Mayonnaise (F) **or** Quartered Tomatoes with Cottage Cheese—French Dressing White Layer Cake with Lemon Filling (FS) **or** Fresh Sliced Peaches

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

1st week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Frankfurters	All beef, 8-1 lb.	15 lbs.	60
Ground Beef	U. S. Good, 5 lb. pkg.	45 lbs.	
Liver	Steer, sliced	10 lbs.	40
Roast, Sirloin (B.R.T.)	U. S. Choice	27 lbs.	80
Round (Bottom)	U. S. Standard	20 lbs.	80
Steak, Swiss	U. S. Good, 4 oz. each	10 lbs.	40
Stew	U. S. Good	15 lbs.	60
LAMB			
Ground, Shoulder	U. S. Good	5 lbs.	20
PORK			
Bacon (Sliced)	24-26-1 lb.	6 lbs.	
Chops, Loin	Grade A, 4 oz. each	35 lbs.	140
Ham (Pullman)	Ready-to-eat	57 lbs.	
Sausage Links	12-1 lb.	10 lbs.	40
Tenderloin	Patty, 4 oz. each	5 lbs.	20
VEAL			
Cutlets	U. S. Good, 4 oz. each	15 lbs.	60
Leg (B.R.T.)	U. S. Good	27 lbs.	80
FISH			
Pike	4 oz. each	20 lbs.	80
POULTRY			
Turkeys (Eviscerated)	Grade A, 20-24 lb. av.	105 lbs.	
Fryers (Eviscerated)	Grade A, 2½ lb. av.	12 lbs.	

Item, Specifications, Amounts & No. of Servings		
FRESH FRUITS		
Apples	Jonathan, 113s	1 box
Bananas	Ripe	30 lbs.
Cantaloupe		10 only
Cherries, Bing		5 lbs.
Grapefruit	Seedless, 70s	1 box
Grapes	Seedless, 28 lb. box	½ box
Lemons		2 doz.
Melon, Honeydew	Crate, 9s	1 crate
Oranges	176s	1 box
Peaches	Basket 20s	11 baskets
Strawberries	Quarts	12 qts.
Watermelon	30-35 lb. av.	100 lbs.
FRESH VEGETABLES		
Cabbage	Bag	50 lbs.
Carrots	Topped, bag	50 lbs.
Celery	Pascal, 30s	1 doz.
Celery	White	1 doz.
Cucumbers		1 doz.
Endive	Curly	6 heads
Lettuce	Head, 48s	1 crate
Onions, Dry	Yellow, bag	50 lbs
Onions, Green	Bunch	1 doz.
Onions, Spanish		6 lbs.
Onions, White	Boilers	3 lbs.
Parsley	Bunch	1 doz.
Peppers, Green		1½ doz.

Item, Specifications, Amounts & No. of Servings			
Potatoes, Sweet	Hamper	50 lbs.	
Potatoes, White	Bag No. 1	400 lbs.	
Radishes	Bunch	2 doz.	
Squash, Summer		20 lbs.	
Tomatoes	Repacked (5 x 6)	1 lug (30 lbs.)	
Watercress	Bunch	½ doz.	
FROZEN FRUITS			
Blueberries	8 lb. can, 5-1 sugar	16 lbs.	
Orange and Grapefruit Sections	Fresh, Chilled, gallon	1 gal.	
Melon Balls	Mixed, 8 lb. can	16 lbs.	
Orange Juice	Con., 32 oz. can	6 cans	
Plums	8 lb. can	8 lbs.	
Strawberries	Sliced, 8 lb. can, 5-1 sugar	24 lbs.	
FROZEN VEGETABLES			
Asparagus	Spears, 2½ lb. pkg.	12½ lbs.	75
Beans, Green	Cuts, 2½ lb. pkg.	40 lbs.	240
Beans, Wax	Cuts, 2½ lb. pkg.	12½ lbs.	75
Broccoli	Stems and buds 2½ lb. pkg.	2½ lbs.	15
Brussels Sprouts	2½ lb. pkg.	2½ lbs.	15
Cauliflower	Buds, 2½ lb. pkg.	5 lbs.	30
Peas	2½ lb. pkg.	15 lbs.	90
Spinach	Chopped, 2½ lb. pkg.	25 lbs.	150
Squash, Winter	3 lb. pkg.	3 lbs.	12
Vegetables, Mixed	2½ lb. pkg.	15 lbs.	90

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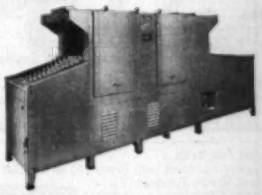

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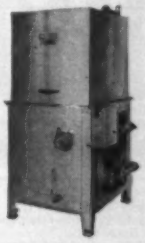

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Choice of timed automatic or push-button models featuring efficient three-way door. Fast, thorough washing action. Built of gleaming stainless steel.

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Speedy, efficient. Easy to operate and clean. 3-speed transmission for thorough mixing, beating or whipping. Auxiliary power socket for accessories. Model TM-30 (30 qt.) shown.

NEW TOLEDO CONVEYOR DISHWASHERS

Exclusive Panoramic Door gives easy access to full length of conveyor. Easiest to clean! Zip-Lok Tubes, one-level tank construction, many more plus features.

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Compact design in 20 lb. or 30 lb. capacity. Work-saving convenience! Peels full charge in 1 to 1¼ minutes. Automatic timer, efficient double-action peeling. Other models 15 lb. to 70 lb.

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2nd WEEK NORTH-NORTHWEST SUMMER SELECTIVE CYCLE MENU

(MENUS TO BE USED DURING JUNE, JULY AND AUGUST)

—prepared by Virginia Reid, administrative dietitian, St. John's Hospital, St. Paul, Minn.

	breakfast	noon	night
monday	Orange Juice **or** Fresh Applesauce Ready-to-Eat Wheat Flake Cereal **or** Oatmeal Scrambled Eggs with Chopped Bacon	Chilled Grape Punch Baked Veal Chop (FS)—Dill Pickles (F) **or** Chili Con Carne Parsleyed Buttered Potatoes (FS) Buttered Corn **or** Buttered New Peas (FS) Lettuce Cubes with Green Pepper Ring with French Dressing **or** Fresh Pineapple Wedges and Strawberries with Sweet Dressing Green Gage Plums in Syrup with Peanut Cookie (F) **or** Marshmallow Pudding (S)	Cream of Tomato Soup Swiss Steak with Mushrooms (FS) **or** Tomato Slices, Strips of Bacon, Deviled Egg on Toast Wedges with Cheese Sauce Buttered Baked Potatoes (FS) Buttered Sliced Carrots (FS) **or** Buttered Cabbage Waldorf Salad **or** Crisp Salad Plate Marble Cake with Seven Minute Icing (F) **or** Apricot Whip (S)
tuesday	Raspberries (F) **or** Tomato Juice (S) Farina **or** Bran Flake Cereal Soft-cooked Egg— Crisp Bacon	Chilled Pineapple Juice Roast Loin of Pork (FS)—Spiced Apple (F) **or** Broiled Hamburger Patty with Fresh Onion Slice Mashed Potatoes with Gravy (FS) Buttered Wax Beans (FS) **or** Buttered Acorn Squash Jellied Royal Anne Cherry-Nut Salad with Mayonnaise (F) **or** Sliced Tomato and Cucumber Salad Rice Pudding with Raisins (S) **or** Chilled Cantaloupe (F)	Split Pea Soup Turkey Turnover with Gravy (F) **or** Broiled Cube Steak (S) Hash Brown Potatoes (F) Stewed Tomatoes **or** Buttered Green Beans (FS) Prune Stuffed with Cream Cheese and Grapefruit Section Salad **or** Sweet-Sour Cabbage Slaw Fresh Tokay Grapes with Molasses Cookies (F) **or** Cranberry Sherbet (S)
wednesday	Grapefruit Juice **or** Stewed Prunes and Apricots Sugar Coated Cereal **or** Malt Meal Cereal Poached Egg Sweet Roll	Chilled Lemonade Meat Loaf with Gravy (FS) **or** Egg and Rice Casserole—Tomato Sauce French Fried Potatoes (F) **or** Mashed Potatoes (S) Buttered Cuts and Tips of Asparagus (S) **or** Buttered Small Whole Beets (F) Melon Ball Salad with Sweet Dressing **or** Head Lettuce Wedge—Sliced Onion—Green Pepper Ring—French Dressing Chocolate Ice Cream—Marshmallow Topping (FS) **or** Fresh Fruit Compote	Chicken-Rice Soup Beef Pie with Biscuit Topping (S) **or** Baked Canadian Bacon—Mustard Sauce (F) Baked Potato with Butter (FS) Buttered Broccoli (F) **or** Buttered Mixed Vegetables (S) Cabbage—Apple—Raisin Salad with Mayonnaise **or** Frozen Fruit Salad Spanish Layer Cake (F) **or** Baked Fresh Pear—Ginger Cookie (S)
thursday	Grape Juice (S) **or** Half Grapefruit (F) Farina **or** Ready-to-Eat Malt Flake Cereal Scrambled Eggs— Link Sausage	Chilled Apple Juice Pot Roast of Beef with Vegetable Gravy (FS) **or** Chow Mein on Chinese Noodles—Soy Sauce Buttered Rice (FS) Buttered Green Beans (FS) **or** Cauliflower Au Gratin Jellied Grapefruit and Orange Salad with Mayonnaise **or** Cole Slaw Angel Food Cake with Lemon Whipped Cream (FS) **or** Fresh Apricots	French Onion Soup Macaroni and Cheese **or** Baked Chicken (FS)—Dressing (F) Mashed Potatoes with Butter (FS) Buttered Brussels Sprouts (F) **or** Buttered Carrots (S) Chef Salad with French Dressing **or** Fresh Peach Half with Cranberry Relish (F) Honeydew Melon with Lime Slice **or** Fudge Pudding with Whipped Cream (FS)
friday	Pineapple-Grapefruit Juice **or** Stewed Fresh Apples Rolled Wheat Cereal **or** Puffed Wheat Cereal Soft-cooked Egg Raisin Toast	Tomato Bouillon Fillet of Sole with Tartare Sauce (FS) **or** Baked Liver with Spanish Sauce Escalloped Potatoes (FS) Buttered Peas (FS) **or** French Fried Eggplant Apple—Date—Celery Salad with Mayonnaise **or** Cottage Cheese Mixed with Shredded Carrot and Chives Pecan Pie with Whipped Cream (F) **or** Stewed Fresh Sliced Peaches (S)	Vegetable Soup with Grated Cheese Shrimp Creole on Rice (F) **or** Veal Cutlet (S) Buttered New Potatoes (S) Buttered Asparagus (FS) **or** Buttered Onions Jellied Fresh Pear with Mayonnaise **or** Tossed Salad with French Dressing Peeled Plums in Syrup with Sugar Cookies (S) **or** Gingerbread with Bananas and Whipped Cream (F)
saturday	Cantaloupe (F) **or** Orange Juice (S) Ready-to-Eat Rice Cereal **or** Rice Farina Poached Egg—Bacon	Chilled Blended Fruit Juice Creamed Chicken on Rusk (FS) **or** Baked Pork Chop with Cheese Mashed Potatoes with Butter Lima Beans in Cream (F) **or** Escalloped Tomatoes (S) Pickled Beet Salad **or** Pineapple Ring with Fresh Melon Center with Sweet Dressing Tapioca Pudding (FS) **or** Fresh Bananas with Cream	Minestrone Soup Salisbury Steak (FS)—Catsup (F) **or** Cold Plate (Macaroni-Vegetable Salad, Sliced Ham, American Cheese, Deviled Egg and Relishes) Cottage Fried Potatoes (F) **or** Baked Potato (S) Buttered Wax Beans (FS) **or** Buttered Mashed Squash Celery Sticks, Carrot Strips, Radishes and Green Onions **or** Fresh Fruit Salad with Whipped Cream (F) Cherry Cobbler with Sauce (F) **or** Butterscotch Pudding (S)
sunday	Orange Juice (S) **or** Strawberries (F) Chocolate-flavored Wheat Cereal **or** Puffed Rice Cereal Scrambled Egg— Canadian Bacon	Chilled Apple Juice Baked Ham with Raisin Sauce (F) **or** Shoulder Lamb Chop with Mint Sauce (S) Candied Sweet Potato (FS) Buttered Beets (FS) **or** Buttered Corn on Cob Cinnamon Apple Salad with Cream Cheese **or** Cucumbers and Onions in Sour Cream Lime Sherbet (FS) **or** Fresh Bing Cherries	Cream of Mushroom Soup Broiled Hamburger on a Bun and Cooked Onions (FS) **or** Cold Slice Roast Beef and Potato Salad French Fried Potatoes (F) Buttered New Peas (FS) **or** Buttered Broccoli Sliced Tomato with Hard Cooked Egg Slices—French Dressing **or** Canned Fruit Salad with Sweet Dressing Maple-Nut Cake with Icing (F) **or** Prune Whip (S)

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

2nd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Ground Beef	U. S. Good, 5 lb. pkg.	70 lbs.	
Liver	Steer, sliced	10 lbs.	40
Roast, Sirloin (B.R.T.)	U. S. Choice	7 lbs.	
Round (Bottom)	U. S. Standard	27 lbs.	
Steaks, Cubed	U. S. Choice, 4 oz. each	5 lbs.	20
Steak, Swiss	U. S. Good, 4 oz. each	15 lbs.	60
Stew	U. S. Good	5 lbs.	
LAMB			
Chops, Shoulder	U. S. Good, 5 oz. each	7 lbs.	20
PORK			
Bacon, Canadian		10 lbs.	
Bacon (Sliced)	24-26-1 lb.	12 lbs.	
Chops, Loin	Grade A, 4 oz. each	10 lbs.	40
Ham (Pullman)	Ready-to-eat	40 lbs.	
Loin (Boneless)	Grade A, 10-12 lbs.	27 lbs.	
Sausage Links	12-1 lb.	10 lbs.	
VEAL			
Chop, Rib	U. S. Good, 5 oz. each	25 lbs.	80
Cutlets	U. S. Good, 4 oz. each	5 lbs.	20
Leg (B.R.T.)	U. S. Good	10 lbs.	
FISH			
Shrimp	26-28 lb.	12 lbs.	
Sole	Frozen, fillets 4 oz. each	20 lbs.	80
POULTRY			
Fowl (Eviscerated)	Grade A, 5 lb. av.	95 lbs.	
Turkeys (Eviscerated)	Grade A, 20-24 lb. av.	30 lbs.	
Fryers (Eviscerated)	Grade A, 2½ lb. av.	37 lbs.	
FRESH FRUITS			
Apples	Jonathan, 113s	1 box	
Apricots	Lug	1 lug	
Bananas	Ripe	40 lbs.	
Cantaloupe	Crate, 45s	1 crate	
Cherries, Bing	15 lb. box	½ box	
Grapefruit	Seedless, 70s	1 box	
Grapes	Tokay	15 lbs.	
Grapes	Seedless	½ box	
Lemons		1 doz.	
Limes		½ doz.	
Melon, Honeydew	Crate, 9s	½ crate	
Oranges	176s	1 box	
Peaches	Basket, 20s	2 baskets	
Pears	Box, 120s	½ box	
Pineapple, Fresh		2 only	
Raspberries, Red	Quarts	4 qts.	
Strawberries	Quarts	9 qts.	
FRESH VEGETABLES			
Cabbage	Bag	50 lbs.	
Carrots	Topped, bag	50 lbs.	
Celery	Pascal, 30s	1 doz.	
Celery	White	½ doz.	
Corn on the cob		1½ doz.	
Cucumbers		1½ doz.	
Eggplant		2 only	
Endive	Curly	1½ doz.	
Lettuce	Head, 48s	1 crate	
Onions, Dry	Yellow, bag	50 lbs.	
Onions, Green	Bunch	2 doz.	
Parsley	Bunch	1 doz.	
Peppers, Green		1 doz.	
Potatoes, Sweet	Hamper	50 lbs.	
Potatoes, White	Bag No. 1	400 lbs.	
Radishes	Bunch	2 doz.	
Romaine		1½ doz.	
Squash, Acorn		7 lbs.	
Tomatoes	Repacked (5 x 6)	1 lug (30 lbs.)	
Watercress	Bunch	1½ doz.	
FROZEN FRUITS			
Cherries	8 lb. can, 5-1 sugar	16 lbs.	
Grapefruit Sections	Fresh, chilled, gallon	1 gal.	
Melon Balls	Mixed, 8 lb. can	8 lbs.	
Orange Juice	Con., 32 oz. can	6 cans	
Orange and Grapefruit Sections	Fresh, chilled, gallon	2 gal.	
FROZEN VEGETABLES			
Asparagus	Cuts, 2½ lb. pkg.	2½ lbs.	15
Asparagus	Spears, 2½ lb. pkg.	10 lbs.	60
Beans, Green	Cuts, 2½ lb. pkg.	25 lbs.	150
Beans, Lima	Small, green 2½ lb. pkg.	15 lbs.	90
Beans, Wax	Cuts, 2½ lb. pkg.	25 lbs.	150
Broccoli	Stems and buds 2½ lb. pkg.	12½ lbs.	75
Brussels Sprouts	2½ lb. pkg.	10 lbs.	60
Cauliflower	Buds, 2½ lb. pkg.	2½ lbs.	15
Peas	2½ lb. pkg.	40 lbs.	240
Squash, Winter	3 lb. pkg.	3 lbs.	12
Vegetables, Mixed	2½ lb. pkg.	2½ lbs.	15

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NEW Ideal COMBINATION

. . eliminates loose ends in CENTRAL FOOD SERVICE

IDEAL Mealmobile, Model 9020-BCT with built-in beverage dispenser and mechanical refrigeration.

The new IDEAL Mealmobile with mechanical refrigeration and built-in beverage dispenser, together with the new Idealmobile, Model FS-100, hot food assembly unit, now make it possible for you to have a complete food service system that is thorough, fast and efficient.

The Mealmobile with its mechanical refrigeration, can now be used as a cold food storage unit. This permits the loading of salads and other cold items well in advance of food serving time and eliminates peaks and valleys in the work load in the kitchen. The new IDEAL Mealmobile in combination with the new Idealmobile hot food assembly unit, enables you to move foods directly from the hot food preparation area to the most convenient assembly area — thus speeding up food service.

The complete IDEAL centralized food service system introduces a cyclical operation in the movement of food from kitchen to patient . . . done the same way every time. And efficiency increases each time!

This IDEAL combination offers efficient centralized food service for all hospitals—regardless of size. Additional units may be added to meet your needs —present and future.

Idealmobile Model FS-100 hot food assembly unit

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Ideal® HOSPITAL EQUIPMENT
Found in Foremost Hospitals

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SWARTZBAUGH MANUFACTURING COMPANY
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3rd WEEK NORTH-NORTHWEST SUMMER SELECTIVE CYCLE MENU

(MENUS TO BE USED DURING JUNE, JULY AND AUGUST)

—prepared by Virginia Reid, administrative dietitian, St. John's Hospital, St. Paul, Minn.

	breakfast	noon	night
monday	Apricot Nectar (S) **or** Fresh Plums (F) Farina **or** Cornflakes Poached Egg Raisin Toast	Cream of Vegetable Soup Roast Loin of Pork with Applesauce (F) **or** Sliced Turkey with Strained Cranberry Sauce (S) Mashed Potatoes with Gravy (FS) Buttered Summer Squash (FS) **or** Stewed Tomato with Green Pepper Waldorf Salad **or** Julienne Beet Salad with Diced Cooked Egg with French Dressing Lady Baltimore Cake (FS) **or** Fresh Pineapple Wedges with Mint	Chicken-Noodle Soup Meat Loaf with Gravy (FS) **or** Broiled Loin Lamb Chop with Sliced Cucumber Pickles Buttered Baked Potato (FS) Buttered Lima Beans (F) **or** Buttered Wax Beans (S) Molded Gingerale Salad with Mayonnaise **or** Chef Salad with French Dressing Date-Nut Bars (F) **or** Nectarines in Syrup (S)
tuesday	Grapefruit Juice **or** Sliced Banana Sugar Coated Cereal **or** Oatmeal Scrambled Eggs—Bacon	Chilled Apple Juice Cube Steak with Catsup (F) **or** Creamed Eggs on Toast (S) Buttered Steamed Potatoes (FS) Buttered Peas (FS) **or** Buttered Carrots O'Brien Sliced Tomato Salad with French Dressing **or** Jellied Orange Souffle Salad Fresh Sliced Peaches (F) **or** Jelly Roll (S)	Cream of Corn Soup Baked Pork Chop with Spiced Apple Ring (F) **or** Broiled Beef Patty (S)—Sweet Pickle Relish Parsley Buttered Potatoes (FS) Buttered Brussels Sprouts (F) **or** Buttered Spinach with Lemon (S) Fresh Fruit Salad with Sweet Dressing (F) **or** Head Lettuce Wedge with French Dressing Chocolate Chiffon Pudding (FS) **or** Fresh Apricots with Date Cookies
wednesday	Raspberries (F) **or** Orange Juice (S) Malt Meal Cereal **or** Shredded Wheat Cereal Soft Cooked Egg Danish Sweet Roll	Chilled Blended Fruit Juice Pot Roast of Beef—Vegetable Gravy (FS) **or** Macaroni and Cheese Buttered Mashed Potatoes (FS) Buttered Cauliflower (F) **or** Orange Beets (S) Tossed Salad with French Dressing **or** Grapefruit and Avocado Salad with French Dressing Maple Ice Cream (FS) **or** Fresh Pear with Chocolate Chip Cookie	Tomato Bouillon Ham Loaf with Cream Mustard Sauce (F) **or** Baked Chicken with Gravy (S) Buttered New Potato (FS) Escalloped Corn (F) **or** Buttered Green Beans with Mushrooms (S) Mixed Melon Slice Salad with Sweet Dressing **or** Cole Slaw Raisin Bread Pudding (FS) **or** Fresh Green Grapes
thursday	Tomato Juice **or** Orange Slices (F) Puffed Wheat Cereal **or** Farina Poached Egg—Grilled Ham	Chilled Apple Juice Baked Veal Shoulder Chop (FS)—Dill Pickle Slices (F) **or** Scrambled Eggs with Chives Creamed Potatoes (FS) Buttered Spinach (FS) **or** Buttered Cabbage Wedge Relish Plate (Celery Sticks, Radishes, Stuffed Olives) **or** Peach Half with Cottage Cheese Bing Cherries **or** Apricot Upside-down Cake with Whipped Cream (FS)	Cream of Mushroom Soup Spaghetti with Meat Sauce (FS) **or** Baked Spareribs Baked Potato with Butter Buttered Asparagus Spears (FS) **or** French Fried Onions Grapefruit Section and Apple Slice Salad with Honey Dressing **or** Shredded Carrot and Raisin Salad Fudge Squares with Powdered Sugar (F) **or** Tapioca Pudding (S)
friday	Stewed Prunes **or** Grape Juice Rice Cereal **or** Chocolate-flavored Wheat Cereal Scrambled Eggs Cinnamon Toast	Cream of Pea Soup Broiled Salmon with Lemon Wedge (FS) **or** Salisbury Steak French Fried Potatoes (F) Stewed Tomatoes (F) **or** Buttered Wax Beans (S) Fresh Pineapple Ring with Grated American Cheese with Sweet Dressing **or** Spiced Beet with Bermuda Onion Slices with French Dressing Lemon Meringue Pudding (FS) **or** Cantaloupe	Clam Chowder Mushroom Chow Mein with Rice and Soy Sauce (FS) **or** Wieners Stuffed with Cheese and Wrapped in Bacon Buttered Steamed Potatoes Buttered Lima Beans in Cream (F) **or** Buttered Tiny Whole Beets (S) Apple-Date-Nut Salad with Mayonnaise (F) **or** Mexican Slaw Strawberry Shortcake with Whipped Cream (F) **or** Custard with Caramel Sauce (S)
saturday	Grapefruit Half **or** Pineapple Juice Rolled Wheat Cereal **or** Puffed Rice Cereal Soft Cooked Egg—Bacon	Consomme Creamed Chipped Beef on Toast (FS) **or** Meat Loaf with Tomato Sauce Buttered Mashed Potatoes Buttered Brussels Sprouts (F) **or** Buttered Carrot Strips (S) Chef Salad with French Dressing **or** Banana Half Rolled in Coconut and Mayonnaise Stewed Fresh Peaches (S) **or** Butterscotch Squares (F)	Cream of Asparagus Soup Cube Steak (FS)—Corn Relish (F) **or** Cold Plate: Cold Boiled Ham, Potato Salad, Celery Hearts, Radishes, Pickle Slices, Olives Hash Brown Potatoes (F) Buttered Peas (FS) **or** Buttered Green Beans Pear and Cream Cheese Ball in Orange Gelatin with Mayonnaise **or** Cucumber and Onion in Vinegar Spice Cake with Butter Icing (F) **or** Vanilla Pudding with Cherry Sauce (S)
sunday	Honeydew Melon (F) **or** Grapefruit Juice Ready-to-Eat Cereal **or** Rice Farina Poached Egg—Link Sausages Sweet Roll	Chilled Cranberry Juice Baked Chicken Maryland (FS) **or** Breaded Pork Chop—Applesauce Mashed Potatoes with Gravy (FS) Buttered Beets (FS) **or** Buttered Brussels Sprouts Fresh Fruit Salad with Whipped Cream **or** Canned Asparagus Rolled in Pimento with French Dressing Vanilla Ice Cream (FS)—Strawberry Topping (F) **or** Fresh Whole Pear with Ginger Cookie	Vegetable Soup Grilled Ham Slice with Mustard (F) **or** Beef Biscuit Roll with Gravy (S) Baked Potato with Butter Parsleyed Buttered Cauliflower (F) **or** Buttered Green Beans (S) Fresh Apricot, Banana Slices and Green Grapes with Sweet Dressing **or** Sliced Tomato, Sliced Onion and Green Pepper Salad with French Dressing Grapenut Pudding (F) **or** Fresh Applesauce (S)

(F)—Full Diet (S)—Soft Diet (FS)—Full and Soft Diet

Bread, butter and a choice of beverages are to be included with each meal.

3rd week market order for perishables (per 50 beds)

Item, Specifications, Amounts & No. of Servings			
BEEF			
Chipped Beef, Dried	U. S. Good	5 lbs.	
Frankfurters	All beef, 8-1 lb.	5 lbs.	
Ground Beef	U. S. Good, 5 lb. pkg.	60 lbs.	
Round (Bottom)	U. S. Standard	27 lbs.	
Steaks, Cubed	U. S. Choice, 4 oz. each	40 lbs.	160
LAMB			
Chops, Loin	U. S. Choice, 6 oz. each	7 lbs.	20
PORK			
Bacon (Sliced)	24-26-1 lb.	12 lbs.	
Chops, Loin	Grade A, 4 oz. each	25 lbs.	100
Ham (Pullman)	Ready-to-eat	50 lbs.	
Loin (Boneless)	Grade A, 10-12 lbs.	35 lbs.	
Sausage Links	12-1 lb.	10 lbs.	
Spareribs	Grade A, 3-1 lb.	10 lbs.	20
VEAL			
Chops, Shoulder	U. S. Good, 5 oz. each	25 lbs.	80
FISH			
Salmon	Red, steaks, 5 oz. each	25 lbs.	80
POULTRY			
Turkeys (Eviscerated)	Grade A	15 lbs	
Fryers (Eviscerated)	Grade A, 2½ lb. av.	62 lbs.	

Item, Specifications, Amounts & No. of Servings		
FRESH FRUITS		
Apples	Jonathan, 113s	1 box
Apricots	Lug	1 lug
Avocado	Ripe	½ doz.
Bananas	Ripe	45 lbs.
Cantaloupe	Crate, 45s	½ crate
Cherries, Bing	15 lb. box	1 box
Grapefruit	Seedless, 70s	1 box
Grapes	Seedless, 28 lb. box	½ box
Lemons		2 doz.
Melon, Honeydew	Crate, 9s	1 crate
Oranges	176s	1 box
Peaches	Basket, 20s	10 baskets
Pears	Box, 120s	½ box
Pineapple, Fresh	Box, 24s	½ box
Plums, Red	Basket (4 x 5)	2 baskets
Raspberries, Red		4 qts.
FRESH VEGETABLES		
Cabbage	Bag	50 lbs.
Carrots	Topped, bag	50 lbs.
Celery	Pascal, 30s	1 doz.
Celery	White	1 doz.
Cucumbers		1 doz.
Endive	Curly	1½ doz.
Lettuce	Head, 48s	1 crate
Onions, Dry	Yellow, bag	1 bag
Onions, Green	Bunch	1 doz.

Item, Specifications, Amounts & No. of Servings		
Onions, Spanish		3 lbs.
Parsley	Bunch	1 doz.
Peppers, Green		½ doz.
Potatoes, White	Bag No. 1	400 lbs.
Radishes	Bunch	1½ doz.
Romaine		1½ doz.
Squash, Summer		25 lbs.
Tomatoes	Repacked (5 x 6)	½ lug (15 lbs.)
Watercress	Bunch	1½ doz.
FROZEN FRUITS		
Apricots	Halves, 8 lb. can, 5-1 sugar	8 lbs.
Cherries	8 lb. can, 5-1 sugar	8 lbs.
Grapefruit Sections	Fresh, chilled, gallon	2 gal.
Orange Juice	Con., 32 oz. can	6 cans
Strawberries	Sliced, 8 lb. can, 5-1 sugar	32 lbs.
FROZEN VEGETABLES		
Asparagus	Spears, 2½ lb. pkg.	10 lbs. 60
Beans, Green	Cuts, 2½ lb. pkg.	7½ lbs. 45
Beans, Lima	Small, green, 2½ lb. pkg.	20 lbs. 120
Beans, Wax	Cuts, 2½ lb. pkg.	5 lbs. 30
Brussels Sprouts	2½ lb. pkg.	27½ lbs. 165
Cauliflower	Buds, 2½ lb. pkg.	25 lbs. 150
Peas	2½ lb. pkg.	25 lbs. 150
Spinach	Chopped, 2½ lb. pkg.	17½ lbs. 105

PLEASE CUT ALONG THIS LINE

THIS PAGE HAS BEEN PERFORATED FOR EASY REMOVAL

Polar *insulated* pitchers and beverage servers are recommended for bedside service where cold water or chilled juices and beverages are used. Because this insulated ware will "hold" a low temperature for hours, no ice is needed, and a possible source of contamination is eliminated.

Designed and made to maintain asepsis

POLAR WARE

stainless steel

water pitchers and beverage servers

The recent furor over unhygienic water servers that made nasty headlines and sordid reading in the nation's press, spotlights — by way of contrast — the completely hygienic potential of Polar stainless steel ware.

All Polar pieces for the sickroom are designed with large openings readily accessible for any hand or mechanical cleaning action. All are deep drawn, seamless stainless steel. There are no temperature limitations that prevent autoclaving, or long exposure to boiling water. And because Polar Ware is made of heavy gauge stainless steel, this ware for bedside service is all but indestructible. That underscores economy, provides a long return on a prudent investment.

Ask the supply house men who call on you. You'll find the best of them carry Polar Ware.

Polar Ware Co.

*3500 LAKE SHORE ROAD
SHEBOYGAN, WISCONSIN

Merchandise Mart — Chicago 54
Room 1455

*415 Lexington Avenue
New York 17, New York

*800 Santa Fe Avenue
Los Angeles, California

Offices in Other Principal Cities
*Designates office and warehouse

HIGH-ENERGY RADIATION

maxitron 2000

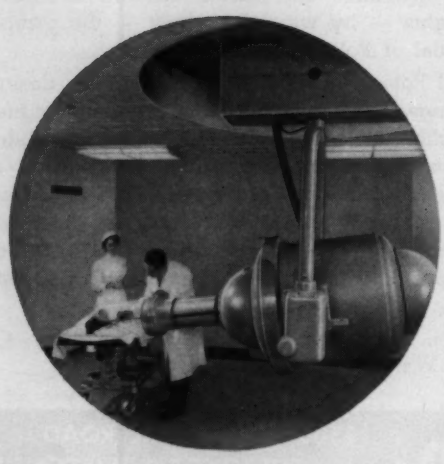
high dose rates at low cost per rad

2-MILLION VOLT X-RAY UNIT—the culmination of more than half a century's experience with radiation. Maxitron 2000 is the most powerful in the complete range of x-radiation therapy sources offered by General Electric.

With the Maxitron 2000, high-energy radiation is generated *electronically* . . . dose rate never decreases due to decay. No source—isotopic or otherwise—compares in maintenance savings. Records of medical centers show that not a single x-ray tube has failed in the entire decade since the first unit was installed! At dose rates provided by the Maxitron 2000, maintenance cost for delivery of 1000 rads to a tumor at 10-cm depth (100-cm square field) *has averaged only pennies!*

For full facts on any range of x-ray therapy equipment, see your G-E x-ray representative. Or write X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin, Room 1003F.

Maxitron is a G.E. registered trademark.



maxitron 1000

MILLION-VOLT X-RAY UNIT—Maxitron 1000 super-voltage therapy unit combines high-energy output, easy operation and duplication of dosage—thanks to *electronically generated* radiation. Here again General Electric quality has reduced maintenance per thousand rads to just *pennies*.

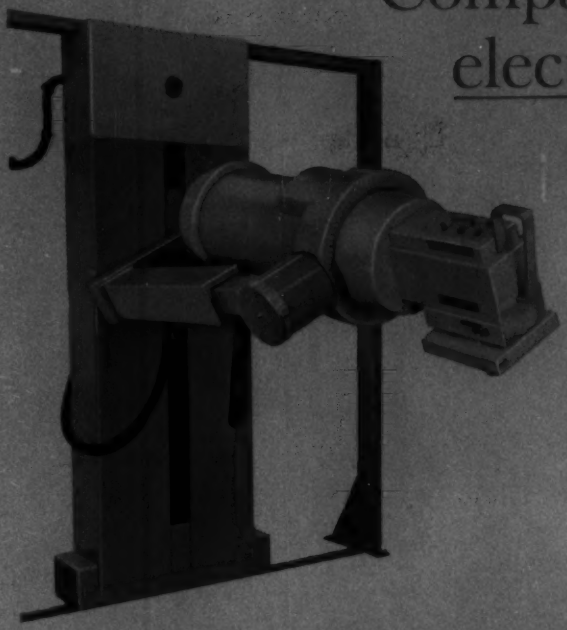
Progress Is Our Most Important Product

GENERAL ELECTRIC

BAYLOR UNIVERSITY MEDICAL CENTER, DALLAS, TEXAS...
2-million volt G-E Maxitron 2000—one of the many now in service at key institutions across the continent. Pleasant surroundings encourage even apprehensive patients to rest easy during therapy.

DEEP, INTERMEDIATE AND SUPERFICIAL THERAPY

Compare these powerful electronic x-ray sources

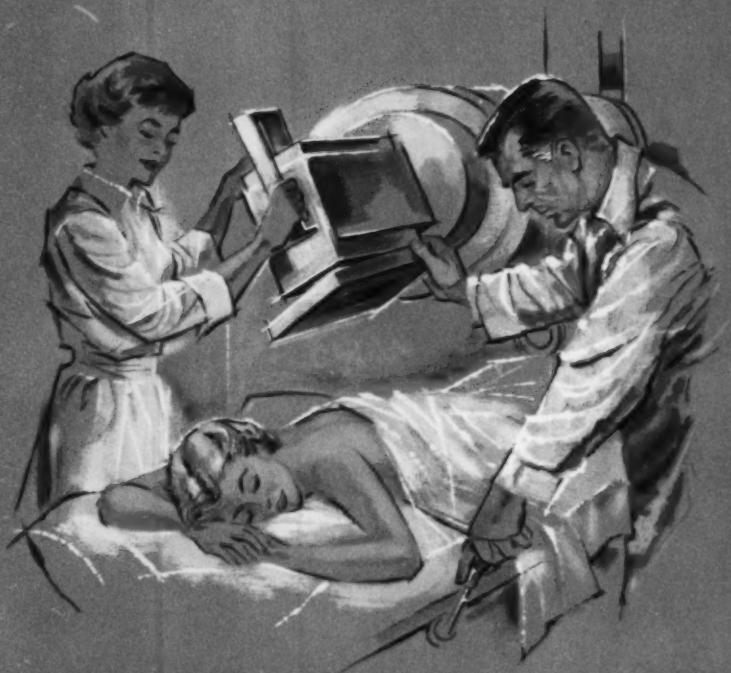


MAXITRON 300

Deep to superficial technic . . . 100 to 300 kvp. Half-value layers ranging from 0.25 mm Al to 4 mm Cu. Dose rate and half-value layer can be dialed right from control console: correct filter positions itself, kvp and ma are preselected *automatically!*

MAXIMAR 250-III

Deep to superficial therapy, at 80 to 250 kvp. Versatile performance and the proved capacity for continuous duty make this a favorite mainstay in many of today's busiest therapy centers. *Requires only 3¼ sq. ft. of floor space.*



MAXIMAR 100

Superficial therapy . . . output from near grenz rays to that obtained at 100 kvp. *More than 5000-r per minute at 15-cm fsd* . . . up to 84% absorption in first 4 mm of tissue. Coverage at 30-cm fsd spans 18-cm circle; dose rate at edge of circle is within 80% of central axis dose rate.

Maximar and Maxitron are G.E. registered trademarks.
Litho in U.S.A.

ISOTOPE TELETHERAPY

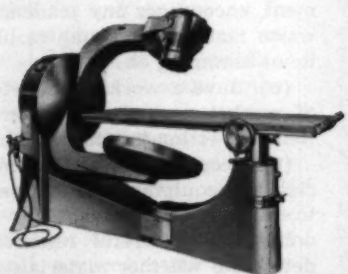
Select from seven cobalt and caesium units

General Electric sells, installs *and services* a complete range of AECL isotope teletherapy equipment, capable of technics from conventional fixed-beam irradiation to complex rotational patterns. All have fail-safe shutters that close automatically in event of power failure.

THERATRON F (shown)—200 r/m/m maximum cobalt-60 source capacity. For fixed- and moving-beam teletherapy.

THERATRON B—165 r/m/m maximum cobalt-60 source capacity. Fixed- and moving-beam capabilities.

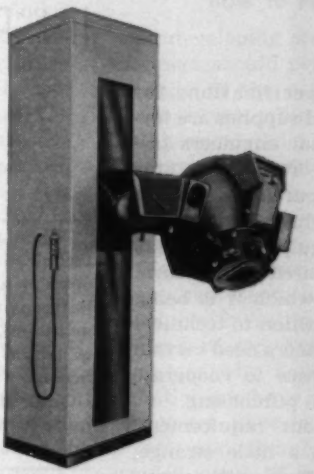
THERATRON C-II—50 r/m/m maximum cobalt-60 source capacity. For both fixed- and moving-beam technics.



THERATRON JR. (shown)—50 r/m/m maximum cobalt-60 source capacity. Fixed- and moving-beam teletherapy provisions.

Progress Is Our Most Important Product

GENERAL ELECTRIC



ELDORADO SUPER G (shown)—200 r/m/m maximum cobalt-60 source capacity. For fixed-beam teletherapy.

ELDORADO G—50 r/m/m maximum cobalt-60 source capacity. Fixed-beam teletherapy unit.

CAESATRON (shown)—1300-curie caesium-137 source capacity. Fixed-beam technic.

• *See your G-E x-ray representative for complete details on equipment for x-ray and isotope therapy. Or write X-Ray Department, General Electric Company, Milwaukee 1, Wisconsin, Room 1009.*

engineering—purchasing

THE ENGINEER'S ROLE IN PURCHASING

by GLENN R. STEVENS

When the purchasing agent needs technical data and an authoritative opinion about specialized equipment, he turns to the hospital engineer for assistance, the author says. He suggests that the hospital engineer should become a resource person for the purchasing department, but this will require his developing the skills of communication and cooperation.

PURCHASING specifications for equipment and supplies are important to hospital engineers because they are responsible for furnishing the purchasing agent with sufficient technical data to insure that the equipment or material to be purchased will perform the function for which it is being considered. In addition to technical competence, engineers need certain other characteristics to cooperate successfully with purchasing.

1. One important requirement, which may seem a little strange, is ability to get along with people. In any work, whether in hospitals, government or private industry, it is recognized that better results can be obtained when individuals learn how to get along with people.

2. Another important requirement is good communication. Communication must be a three-way proposition—up, down and lateral. Unless the engineer is willing to communicate with the individual or department requisitioning new equipment, or planning alterations involving engineering specifications, so that he clearly understands the need to be met, he cannot develop clear and understandable specifications.

Furthermore, good communication will enable the engineer to recommend materials, equipment or tools that will better meet the need at less cost—either first cost or future maintenance cost.

Communication helps the engigeer to understand purchasing methods and procedures. Then, he can supply the purchasing agent with information and data suitable for his use. Often the engineer becomes arbitrary about specifications because it is a technical matter and he thinks he is an authority in technical matters. Therefore, it is important that specifications be developed after good communication with the user and with the purchasing agent. A good rule for engineers is: *Don't be a technician —be a consultant.*

Glenn R. Stevens is director of engineering service, Department of Medicine and Surgery-Operations, Veterans Administration.

HOW TO PURCHASE WISELY

3. Purchasing involves many points that definitely affect the engineer. Here is a partial list of them:

(a) Develop the information and place the order far enough in advance to avoid emergency purchases. This calls for good planning by management and engineering.

(b) Consider the standard packaging of materials common to the trade. Order in units that will result in better price quotations whenever possible.

(c) Purchase in a group the small supplies that are used continually. Submit a list of similar items, which can be procured from the same type of supplier, so that a worthwhile bid can be solicited. This often results in better prices and more uniform materials.

(d) Consider delivery time. Keep informed about the normal delivery time so that orders can be requested sufficiently in advance to insure delivery when needed. This can be done best, with items frequently ordered, through the establishment of a running inventory, with a minimum stock quantity to indicate when reordering should be done. This should also eliminate the building up of an unnecessary inventory. It is bad practice, and shows lack of good management, to carry excess supplies in the engineering department. It ties up capital investment, encourages any tendency to waste material and may result in items becoming obsolete.

(e) Have a working knowledge of market costs for common use items for estimating future jobs.

(f) Keep abreast of new materials and equipment on the market to insure getting the most for your dollar. Make careful research to determine whether materials with higher first cost may actually be cheaper over a period of years. In other words, evaluate in your economic study the annual maintenance costs of new materials and/or equipment. Often when an economic study is made, it shows definitely that the cheaper materials may be more costly in terms of maintenance.

The engineer and the purchasing

agent should know the reputation of the manufacturer. How long has he been in business? Does he enjoy a good reputation for adjusting deficiencies when they occur? Where has his equipment been used and what are the opinions of the users about it? Such investigation often pays big dividends, particularly in private hospitals that are not restricted to bid requirements. It is essential that the hospital engineer study these economic aspects of the procurement of new equipment.

HOW TO WRITE "SPECS"

Specification writing is in itself a specialty in the engineering field. This does not mean that maintenance engineers cannot develop good, sound specifications. If they have not done so, they should purchase or borrow a book on specification writing. There are several on the market.*

Federal specifications can be helpful. These are obtainable through the Government Printing Office. The federal government is now establishing equipment standards that may be helpful in some cases. An index of all federal specifications and standards is for sale on a subscription basis by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. When using federal specifications, the engineer should keep in mind that these are written with rather broad limits and that, as a result, they permit bidding by most manufacturers. They may be too broad for specific use by the hospital engineer, but they will serve as a guide in his specification writing. He can make limitations as restrictive as he wishes.

One important *don't* in specification writing is: *Don't use a particular manufacturer's so-called specification.* They too often stress some feature of their equipment that will prevent other bidders from complying entirely with the specification. Specifications should be written on the basis of the result desired or the quality of the materials wanted. Frequently, specifications are written by describing a piece of equipment or material shown in a catalogue from a national supplier with the expression "or equal" added. This can get the buyer into no end of trouble. If he has not already learned this, the engineer will find it difficult to defend his stand that the material or equipment of a certain manufacturer does not meet his specifications of "or equal".

In developing specifications for specialized equipment or for the alteration or construction of an addition, the engineer will find it beneficial to have one or two reliable contractors' or manufacturers' representatives visit the site and discuss the problem with him. Often they will make helpful suggestions, which can be incorporated into the final specifications after they have been analyzed to insure that they have not become exclusive.

It is well to indicate, when appropriate, that the bidder will visit the site and make his own field measurements. In other instances, it is well to insist on shop drawings for review before final acceptance.

In procuring certain types of equipment using electric current, it is most important to define clearly the electrical characteristics required. Be sure that the hospital's supply of current will be adequate to meet new demands, and that existing wiring will carry the load. Otherwise, these should be included in the total project of procurement of new equipment. Standard national codes for electrical work, plumbing work, etc., should be consulted and used. These are the *National Plumbing Code (Minimum Requirements for Plumbing)*, published by the American Standards Association, New York, and the *National Electrical Code*, published by the National Board of Fire Underwriters, New York, and the National Fire Protection Association, Boston.

If the engineer is considering specifications for road or sidewalk construction, he should consult with local contractors or state authorities to determine what the local practice is so that his specifications will not call for mixes or materials not in common use locally. On occasion, he may wish to buy equipment installed under the supervision of the manufacturer. Such supervision should be included in the bid price.

HOW TO PROVIDE ELASTICITY

In developing specifications, the engineer should permit reasonable latitude in the established limits so that reputable manufacturers will have no difficulty in providing equipment or materials meeting the end objective—and he should insert a guaranty clause that can be made binding.

Claims of manufacturers and their representatives should be carefully investigated before an order is placed. Equipment manufacturers who have national distribution and have been in business for years have a reputation to protect and, therefore, can be depended upon to rectify errors if they occur. A "fly-by-night" salesman may sell the hospital equipment or materials with sad results. For example, the hospital may be unable to get repair parts or service.

Low first cost is not necessarily good economy. After the engineer has conferred with the ultimate user and understands the procedure followed by the purchasing agent, then he can develop clear, concise and complete specifications. Specifications should be reviewed to eliminate wordy descriptions that are ambiguous and offer dishonest bidders an opportunity to dispose of second-rate material and still clear themselves by stating that their material or equipment met the specifications. ■

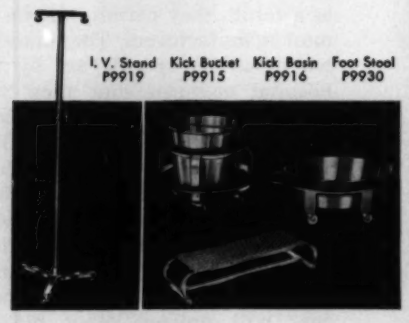
*Among these are *Architectural Specifications*, by H. R. Sleeper (John Wiley & Son); *Engineering Construction*, by R. W. Abbott (John Wiley & Son); *Specifications*, H. G. Edwards (Van Norstand); and *Streamlined Specification Standards*, B. J. Small (Rheinhold).

Read the July 1
SMALLER HOSPITALS ISSUE

alumiline

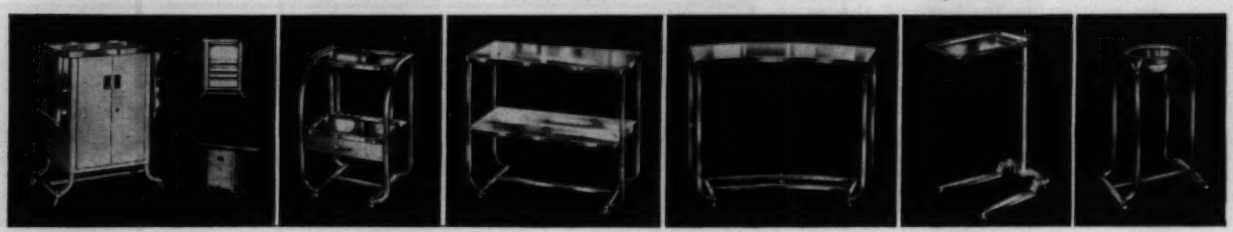
Septicart
Cat. No. P9996

Isolate Contaminated Articles in the O. R.—**New Aloe Septicart** is a mobile receptacle for the systematic collection, immediate isolation, and removal of all contaminated material in the operating room. It is easily moved to points of collection and quickly withdrawn on easy-rolling casters. Septicart is fitted with a leak-proof polyethylene bag of large capacity to hold soiled linens. Solution tank of stainless steel has removable stainless steel basket to receive all discarded instruments. Below the instrument tank is a receptacle for soiled dressings, etc. to be discarded; fitted with a leak-proof polyethylene fold-over bag. Below the glove receptacle is a utensil receptacle, also fitted with a leak-proof polyethylene bag for easy removal. The red color of the bags serves as a warning code denoting contamination to all who handle.



I. V. Stand P9919 | Kick Bucket P9915 | Kick Basin P9916 | Foot Stool P9930

Anesthesia Cabinet—P9949 | Anesthetist's Stand—P9937 | Instrument Tables | Curved Instrument Tables | Mayo Rack—P9920 | Solution Stand—P9960



....Meets Today's Most Rigid O. R. Standards

Aluminum and stainless steel for superior conductivity, easy-to-clean, aseptic construction. Distinctive style, superbly functional

Alumiline operating room furniture is an Aloe exclusive development. Designed and fabricated entirely in our own factory, it has been given special features which make it uniquely fitted for use in the surgery.

Distinctive—Design-Coordinated

The graceful, distinctive, square-tube frames provide the strength and pleasing unity of design which are characteristic of the entire line. Alumiline is completely functional—every unit has been developed to serve a definite purpose with maximum efficiency. As a group, Alumiline is design-coordinated to meet the stringent functional demands of modern surgical technics.

Maintenance-Free Construction

Stainless steel and aluminum are combined to give permanent protection against corrosion and rust. Sturdy, welded construction assures lasting rigidity; exclusive H-frame cross bracing at the lower part of the unit provides unusual strength. In contrast to ordinary bolted construction, Alumiline will remain rigid permanently and will therefore last many times longer under the hard conditions of daily institutional use.

Aluminum parts are chemically oxidized and finished to retain a permanently smooth surface that is easy to clean and will never tarnish in normal use.

The stainless steel used in Alumiline has a No. 4 Satin finish, which reduces glare and shows no finger prints. The light weight of Alumiline permits easier handling; causes less damage to hospital floors.

Electrically Conductive

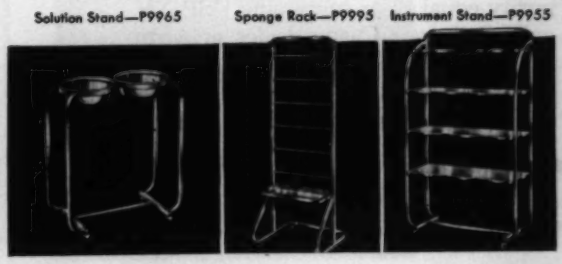
Because of superior conductivity, aluminum and stainless steel are the preferred materials for use in the O. R. Alumiline in the operating room forms an important link in your chain of precautions against explosion hazards of static electricity.

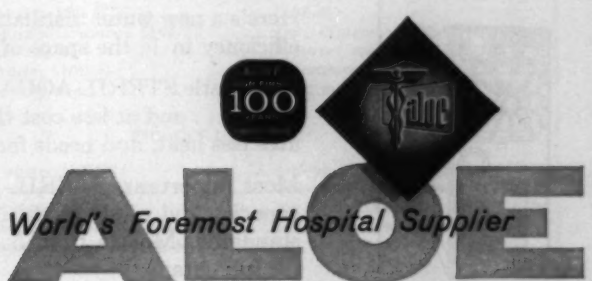
With the naturally conductive aluminum and stainless steel construction, conductive casters complete the cycle of safety measures that make Alumiline safe for use in the presence of anesthetic gases.

Write or see your Aloe Representative for complete information.

Operator's Stools—P9925—P9927 Linen Hamper—P9970 Utility Stand—P9943

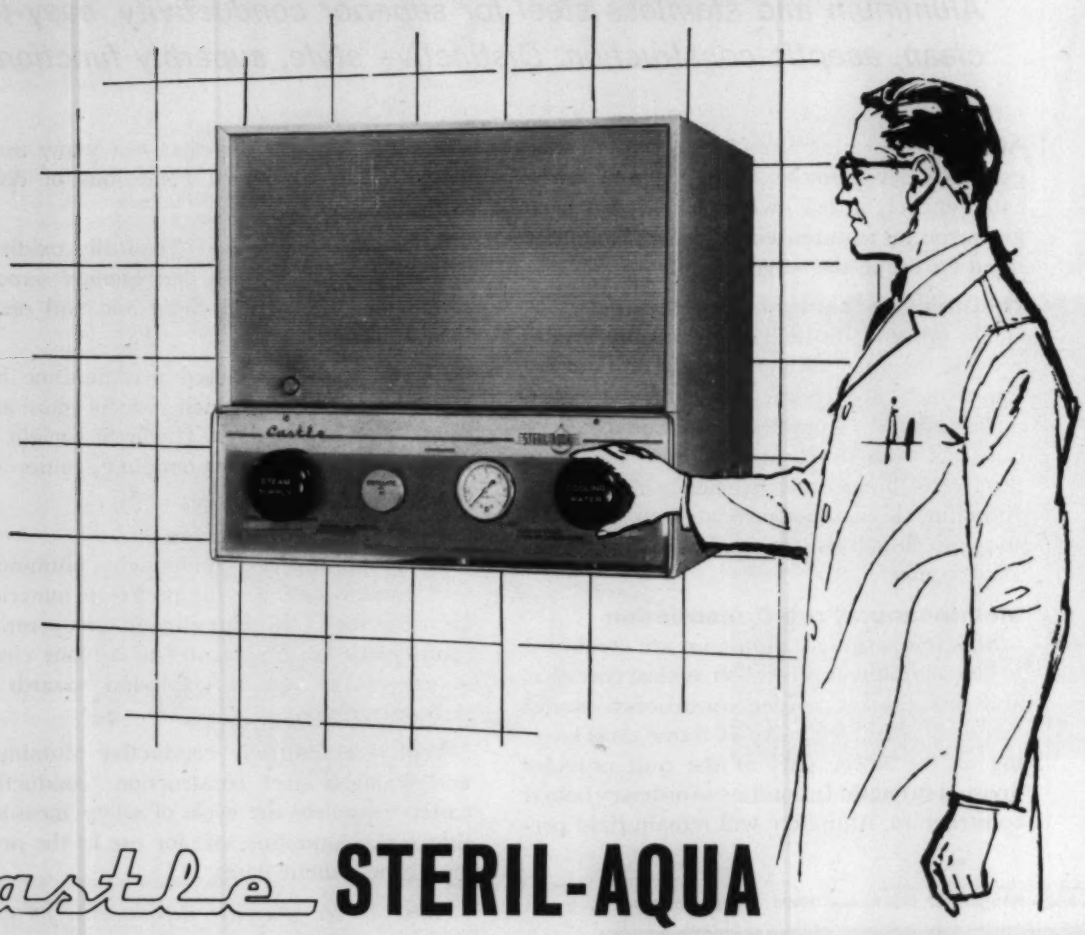
Solution Stand—P9965 Sponge Rack—P9995 Instrument Stand—P9955



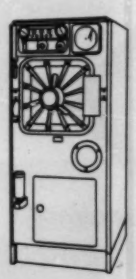


A. S. ALOE COMPANY
DIVISION OF THE BRUNSWICK-BALKE-COLLENDER COMPANY
1831 Olive Street, St. Louis 3, Mo.
18 FULLY STOCKED DIVISIONS COAST-TO-COAST

Today's most efficient still is today's most compact still...



Castle STERIL-AQUA



Write, too, for details on Castle's new Orthomatic Steam and (shown above) Sterox - O - Matic Ethylene Oxide Gas Sterilizers.

Here's a new water distillation process for hospitals that offers you greater efficiency in ⅕ the space of conventional units!

The Castle STERIL-AQUA produces pyrogen-free water direct from boiler steam . . . and at less cost than any other still. It requires less steam, radiates less heat, and needs far less maintenance.

Most important, STERIL-AQUA operates consistently at or above rated capacity and produces distillate of purity equal to or surpassing USP XV standards. Models from 5 to 500 gph. Call your Castle dealer or write for full details.

Castle LIGHTS AND STERILIZERS

WILMOT CASTLE CO., 1702-5 E. HENRIETTA RD., ROCHESTER 18, N. Y.

equipment and supply review

Precleaned slides and cover glasses (10E-1)

Manufacturer's description: Precleaned microscope slides and cover glasses are thin, flat and highly resistant to corrosion or fogging. Annealed to minimize chipping and breakage

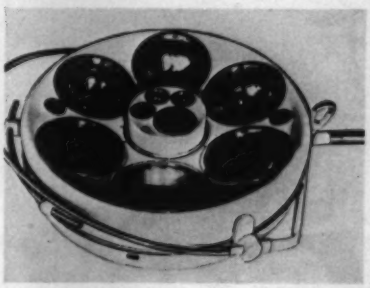
they are precision-sized for accurate uniformity and come in a cellophane-wrapped, hinged dispensing box with lint-free lining. *Erie Scientific, Dept. H9, 693 Seneca St., Buffalo 10, N.Y.*

Urinary drainage bag (10E-2)

Manufacturer's description: The urinary drainage bag and tubing are a complete unit ready to use with no extras to buy. With one simple operation, bag may be snapped to any hospital bed, litter, wheel chair or home bed, or it may even be tied to the patient's leg. A second simple operation joins the tubing to the catheter. Tubing cannot be contaminated from handling since bag already has the sterile tubing inserted. Tubing cannot pull out of bag when patient turns over in bed. Measurements are easy to read because the bag remains square and printing is in bold lettering. Bag is easily removed for emptying and flushing. *Hospital Supply and Development Co., Dept. H9, 3109 Forbes Ave., Pittsburgh 13.*

Surgical light-movie camera (10E-3)

Manufacturer's description: The operating light, with built-in 16 mm. motion picture camera, offers the flexibility and dependability vital to surgical photographic technique. Frame speed variability, lens turret interchangeability and shutter



stabilization are some of the features characteristic of this combination. The powerful incandescent light sources offer excellent cavity penetration, plasticity and control. *Hospital Equipment Div., Overseas Service Corp., Dept. H9, 1219 Dupont Circle Bldg., Washington 6, D.C.*

Stopwatches (10E-4)

Manufacturer's description: Stopwatch capacity and legibility have been increased through design changes, which permit registering the minutes on a large red circle around the central shaft, rather than on

New product descriptions included in this section are condensed from reports furnished by manufacturers and distributors. Descriptions are included here for informational purposes and such inclusion does not constitute endorsement by the American Hospital Association.

▶ If you wish to have your name sent direct to the manufacturers of products and distributors of literature described in this review, check the appropriate items on this coupon, sign your name and address, clip and mail to the Editorial Department of HOSPITALS, J.A.H.A., 840 North Lake Shore Drive, Chicago 11, Illinois.

PRODUCT NEWS

_____Precleaned slides and cover glasses (10E-1)
_____Urinary drainage bag (10E-2)
_____Surgical light-movie camera (10E-3)
_____Stopwatches (10E-4)
_____Suburban tractor (10E-5)
_____Oxygenator (10E-6)
_____Operating room table (10E-7)
_____Hot and Cold food serving unit (10E-8)
_____Tape dispenser (10E-9)
_____Recovery room unit (10E-10)
_____Laboratory washer (10E-11)
_____Food service equipment (10E-12)

PRODUCT LITERATURE

_____Emergency power (10EL-1)
_____Anatomical diagrams (10EL-2)
_____Sterilization agent (10EL-3)
_____Stainless steel equipment (10EL-4)
_____Fire protection equipment (10EL-5)
_____Antiseptic skin detergent (10EL-6)
_____Operating room storage (10EL-7)
_____Air control (10EL-8)
_____Bandaging procedures (10EL-9)

NAME and TITLE _____

HOSPITAL _____

ADDRESS _____

(Please type or print in pencil)

the conventional off-center circle with a stub hand. Sixty minutes of elapsed time may now be registered rather than the usual 30 minutes. Other features include a dull back finish and bezel ring which does not reflect light; an intentionally flat back (rather than convex) which won't rock on the laboratory or work table; jeweled shock absorbers; unbreakable non-glare crystals, and fully-jeweled escapement levers. *Heuer Timer Corp. Dept. H9, 441 Lexington Ave., New York 17.*

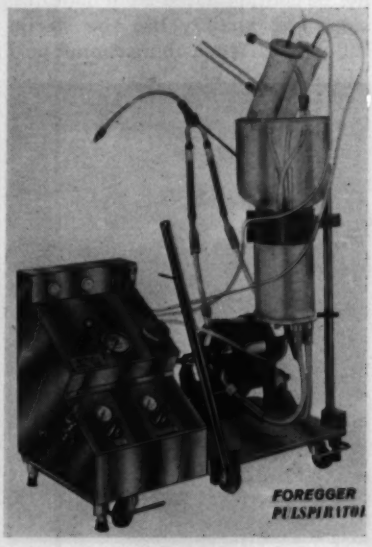
Versatile tractor (10E-5)

Manufacturer's description: This tractor

is a solution to all outdoor maintenance problems. Some 22 attaching tools enable the tractor to be used on all types of jobs. In warm weather, this handy tractor with a heavy duty, three-gang reel mower grooms large lawns and parkways in wide 5-foot swaths. In the fall, a 4-foot trailing rake quickly cleans leaves and debris from lawns. When snow comes to clog driveways and sidewalks, a reinforced, front-mounted blade turns the tractor into a snowplow. *Wheel Horse Products, Inc., Dept. H9, 51467 U.S. 31, South Bend 17.*

Oxygenator (10E-6)

Manufacturer's description: The low-volume pump oxygenator requires no donor blood priming. The pulspirator, achieving complete bypass of the blood from the heart and lungs, permits direct-vision surgical procedures. Other apparatus developed during recent years for such open-heart surgery rely on donor blood for priming—usually from 3 to 24 pints of fresh blood. This is eliminated because the



MISS PHOEBE

NO. 35 IN A SERIES

"I'm going back to horse racing — they didn't tell me we'd have to outlast Everest & Jennings chairs!"

Elevating legrest model has 8" casters balance-positioned to compensate for weight of casts.

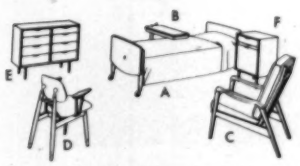
Everest & Jennings chairs *do* last.
Their maneuverability lasts, their smooth performance lasts, their bright easy-to-clean beauty lasts.
Only one thing ever changes: their economy becomes more apparent every year you own them.

Specify **EVEREST & JENNINGS** chairs for your hospital

EVEREST & JENNINGS, INC.,
1803 PONTIUS AVE., LOS ANGELES 25, CALIF.

CARROM 3000 GROUP

the traditional warmth of walnut in trend-setting design



A—E59-9W-4 Electric Adjustable Height Bed
B—3-1950 Overbed Table
C—3-1108S Hi-Back Convalescent Easy Chair
D—3917S Arm Chair
E—3055 Double Chest*
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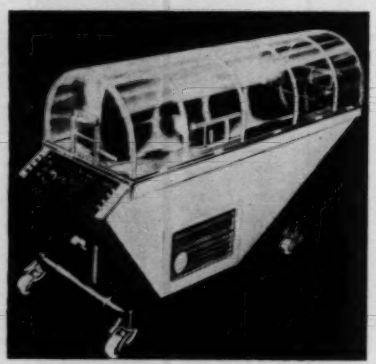
pulspirator is primed with one liter of physiologic saline solution which remains in the oxygenator during the operation as a stratum above the blood. No electricity is required as it operates by oxygen from line pressure or cylinder and may be converted instantly to manual operation. *The Foregger Co., Inc., Dept. H9, Roslyn Heights, L.I., N.Y.*

Operating room table (10E-7)

Manufacturer's description: This operating room table was designed especially for brain and heart operations and has proved to be of value in the treatment of shock due to hemorrhage. It incorporates an air cooling and warming system, covering a range of temperature from -10°C. to 50°C. (+14°F. to +122°F.). Included are removable plastic covers, four of which have shutters. The table weighs 900 lbs., is 85½ in. long and 26 in. wide. *Heljestrand, Auto-Hypotherm Div., Dept. H9, Hamngatan 7-9, Stockholm, Sweden.*



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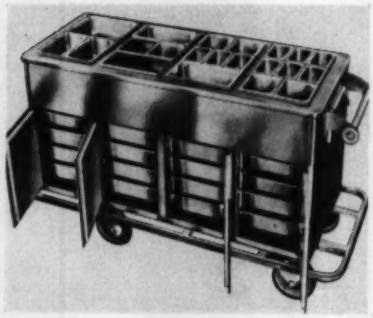
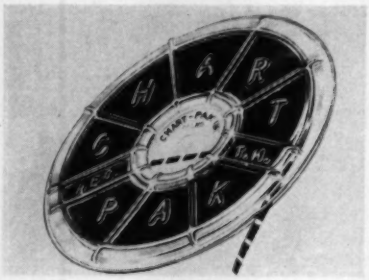
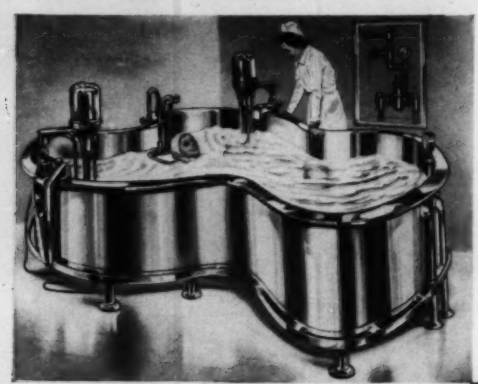
Manufacturer's description: This portable hot and cold serving unit was especially designed to handle the problem of feeding large numbers of persons at a distance from the food preparation area. Units provide extraordinary capacity, up to 348 quarts of food, yet are small enough to be easily maneuvered by one operator. They are constructed of nickel-bearing, stainless steel, polished to high luster satin finish. The body and doors are insulated with fiberglas, and heat is controlled by thermostat. *Swartzbaugh Mfg., Co., Dept. H9, Murfreesboro, Tenn.*



Tape dispenser (10E-9)

Manufacturer's description: A dispenser package for precision-slit, pressure-sensitive tapes. All charting and drafting tapes, ranging in





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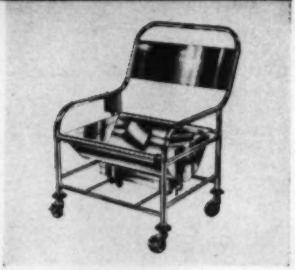

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width from 1/64 in. to 2 in., are individually packaged in these dispensers. The dispenser gives the tape maximum protection against dust, dirt, ashes, etc., while the rigid sides prevent crushing. Storing is made easier because the flat sides allow stacking. Tapes can be identified at a glance through the clear plastic sides and also by a strip in the center. *Chart-Pack, Inc., Dept. H9, Leeds, Mass.*

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Manufacturer's description: An intensive-care nursing and service unit for hospital recovery rooms has been developed to bring all facilities for special nursing care to the bedside. Two patients can be served simultaneously from the ceiling-mounted unit which extends to nursing level when needed, and telescopes above head level when not in use. The station makes it possible to bring all supply lines, oxygen, vacuum, and electricity, directly to the bedside without crossing the floor. *National Cylinder Gas Div. of Chemetron Corp., Dept. H9, 840 N. Michigan, Chicago 11.*

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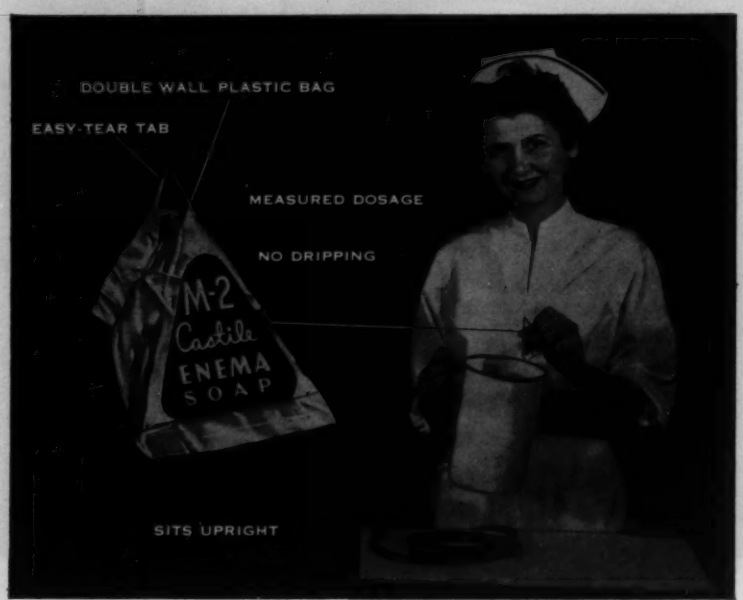

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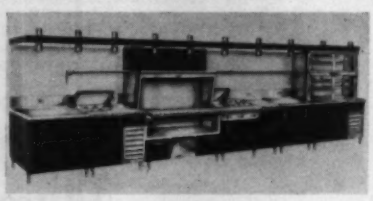

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product literature

SEE COUPON, PAGE 91

Emergency power (10EL-1)—Information in this booklet concerns standby emergency power for hospitals, giving details on installation and advising how to estimate costs and size of generator set to install. *Allis Chalmers, Dept. HL9, 1135 S. 70th St., Milwaukee 14.*

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Anatomical diagrams (10EL-2)—This catalogue illustrates anatomical diagrams of 250 different body areas and organs with parts relationships. Each diagram is available in rubber stamp form, adhesive backed labels, charts and projection slides. Ask for Booklet 54. *United Surgical Supplies Co., Inc., Dept. HL9, 154 Midland Ave., Port Chester, N.Y.*

Sterilization agent (10EL-3)—A brochure giving complete information on a cold sterilization agent. *Davol Rubber Co., Dept. HL9, 69 Point St., Providence 2, R.I.*

Stainless steel equipment (10EL-4)—A handbook telling how to take care of stainless steel hospital equipment. *Crucible Steel Co. of America, Dept. HL9, P.O. Box 2518, Pittsburgh 30.*

Fire protection equipment (10EL-5)—Specifications, descriptions and illustrations are supplied in a publication about all types of fire protection equipment. *American La France, Div. of Sterling Precision Corp., Dept. HL9, 100 E. LaFrance St., Elmira, N.Y.*

Antiseptic skin detergent (10EL-6)—A research bulletin on an antiseptic skin detergent for surgical scrub-up is available. *Huntington Laboratories, Inc., Dept. HL9, Huntington, Ind.*

Operating room storage (10EL-7)—Operating room storage boxes, racks and canvas sterilizing rolls for various instruments are pictured in this booklet, along with other information and techniques for storing items. *Zimmer Mfg. Co., Dept. HL9, N. Detroit St., Warsaw, Ind.*

Air Control (10EL-8)—The subject of this booklet is the importance of purity of air in control of spread of infection in hospitals, treated in question and answer form. *Surface Combustion, Div. of Midland-Ross Corp., Dept. HL9, 2375 Dorr St., Toledo 1.*

Bandaging procedures (10EL-9)—A 16-page booklet on bandaging procedures, with descriptions in detail, and with diagrams for bandaging in orthopedics, surgery, neurosurgery and podiatry. *General Bandages, Inc., Dept. HL9, 8300 Lehigh Ave., Morton Grove, Ill.*

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1. Lynn, H.B.: Postgrad. Med., 22:429, 1957.
2. Dancis, J.: Postgrad. Med., 22:194, 1957.

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HOW MANY CLOSETS? HOW MANY CARTS?

If she is consulted in the early blueprint stages, the housekeeper can give valuable help in planning physical needs of the department

by HELEN K. JOHNSON

"WHAT DO they do here at Menninger's, let the housekeeping department design all their buildings?" "Look at the size of these janitor's closets and how conveniently they are located." These comments are typical of those made by salesmen, visitors and friends as they look at the floor plans of our adult and children's hospitals—the latter just now under construction. They seem amazed that so much care and thought has gone into planning the facilities for the housekeeping services. Our secret, if it can be called a secret, is this: In the construction or remodeling of all our buildings, the executive housekeeper—along with other department heads—is made a member of the planning committee, from the time of the first working drawings to the approval of the final blueprints.

Housekeeping involves all areas of the hospital. Since 90 to 95 per cent of the housekeeping budget is spent for labor, the housekeeping employee's labor is not efficient if he is spending his time transporting equipment from one floor to another or traveling all over the hospital for supplies. Too often, housekeeping facilities are squeezed into any available small space, at the end of a corridor, under stairs or in the basement, where they are both inconvenient and inadequate for economical operation.

Helen K. Johnson is executive housekeeper, the Menninger Foundation, Topeka, Kan.

New buildings are products of collective planning, the author states, which means that all department heads should be members of the planning committee. The author describes particularly the role of the executive housekeeper on the planning committee, with specific suggestions about how she can improve housekeeping facilities' design and location.

SUPERVISORS REVIEW PLANS

At the Menninger Foundation, each department head has an opportunity to familiarize himself with building plans as they progress. After the preliminary blueprints have been prepared by the architect, blue line copies of these prints are sent to each department head for study and suggestions.

After department heads have returned their copies of the plans with their suggestions and criticisms, a revised set is prepared. When a final floor plan has been approved, department heads are asked to detail the specifications for the facilities of their own departments. For the housekeeping department, the housekeeper details specifications for the height and depth of shelving, for electrical outlets for power equipment, cabinet or door locks (if desired) for storage areas, window washing safety devices, racks for hanging cleaning tools, etc.

For example, heavy 5-gallon cans need an 18-inch clearance, if they are to be lifted onto a shelf. Gallon jugs are 12 inches high, but need only a 13-inch shelf to allow for clearance. Actually planning what will be stored in the storage area and carefully detailing the specifications for the storage area will increase space utilization after the building is built. The housekeeper also makes suggestions for floor coverings, counter tops, draperies and drapery rods, wainscoting, stair treads and, later, suggestions for furniture and accessories.

COLLECTIVE PLANNING NEEDED

At the Foundation, we have found that by working together, each department head can better

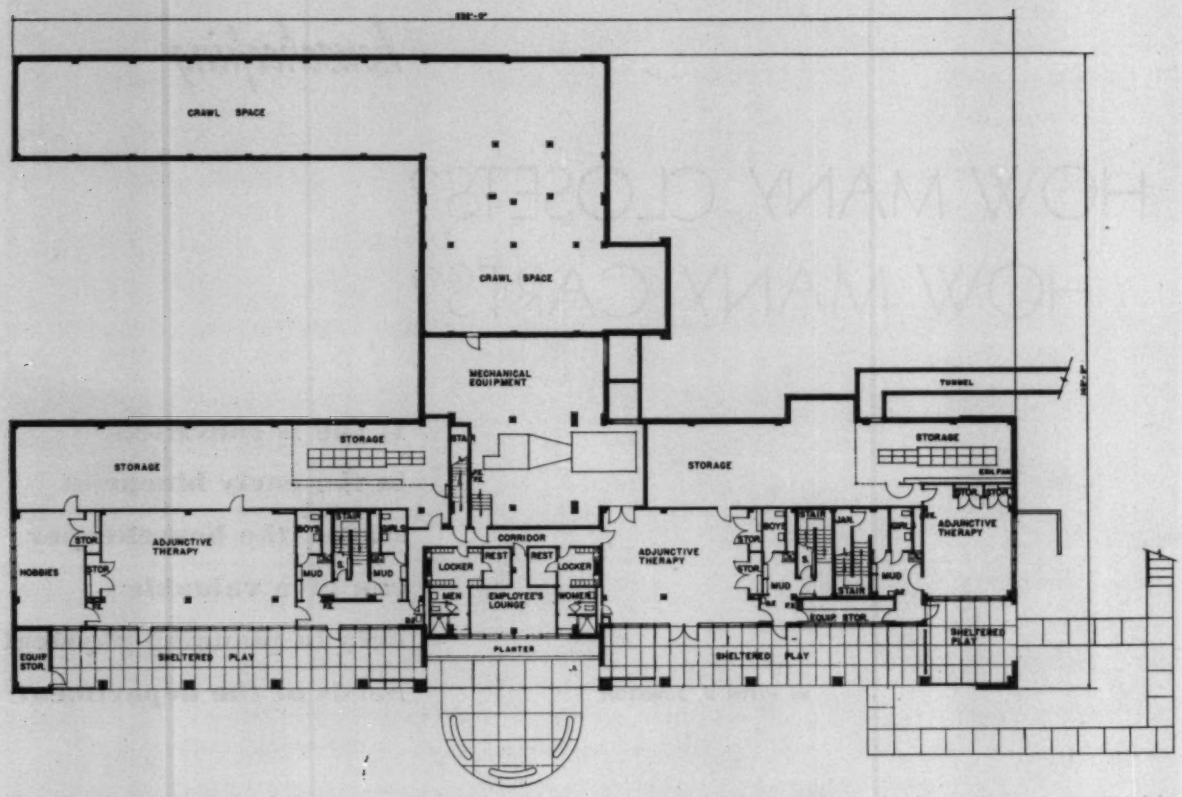

Fig. 1—Lower level, Children's Psychiatric Hospital, the Menninger Foundation, Topeka, Kan.

understand the problems of the others. New buildings are products of collective planning, and should any of us be required to sacrifice space or location, we know the reasons for the decision. By being given the opportunity to familiarize herself with the buildings as they are being planned and knowing the decisions that are made about the installation of any new materials (such as new types of floor covering, acoustical tile, wood finishes, or drapery fabrics), the executive housekeeper has time for research on maintenance of the material before the building is completed.

One of the first things the housekeeper tries to determine is the number of people needed to service the proposed new building. Is a maid cart needed for each employee? If so, is there enough space for storing these carts? How many power machines will be needed for scrubbing, waxing and cleaning? Is there adequate storage space for them? How many mop sinks should there be? Are the janitor and linen storage closets located where they will be easy to supply and convenient to use?

JANITOR, LINEN CLOSET DESIGN

If possible, a main janitor closet should be located centrally on each floor of a hospital building. It should be large enough to store everyday cleaning equipment and enough paper goods and cleaning supplies to last at least a week. It should contain a mop sink with a mixing faucet and an attached flexible tube or hose. If the corridors are long, an additional, small janitor closet should be located near the end of the corridor, as a second source of water and emergency supplies.

In our hospital, the housekeeping department takes care of linens. We have found that our linen storage closets operate more effectively if we have permanent shelving on only one end of the linen room and use portable shelf carts which can be loaded in the laundry, transported to the linen closet, and traded out—the empty cart being taken back to the laundry. We built our main linen closets to accommodate a number of these shelf carts. Linen closets that hold one portable shelf cart are placed at intervals along the corridors. These carts, too, are traded out once a day.

PLANNING FOR CHILDREN'S HOSPITAL

The Menninger Foundation is building a children's psychiatric hospital composed of three buildings—two hospital buildings and one school-adjunctive therapy building. One of these is a 30-bed hospital building that will house children from 5 to 12 years of age. It also contains offices, treatment rooms, a kitchen and service areas. It was decided that housekeeping personnel would make all beds and clean all areas except the mechanical equipment room and the storage areas.

Knowing that one employee can clean a larger area if it can be cleaned when it is unoccupied, we plan to do as much cleaning at night as possible. The entire building will contain slightly more than 32,000 sq. ft. of floor space. Eliminating the areas not to be cleaned

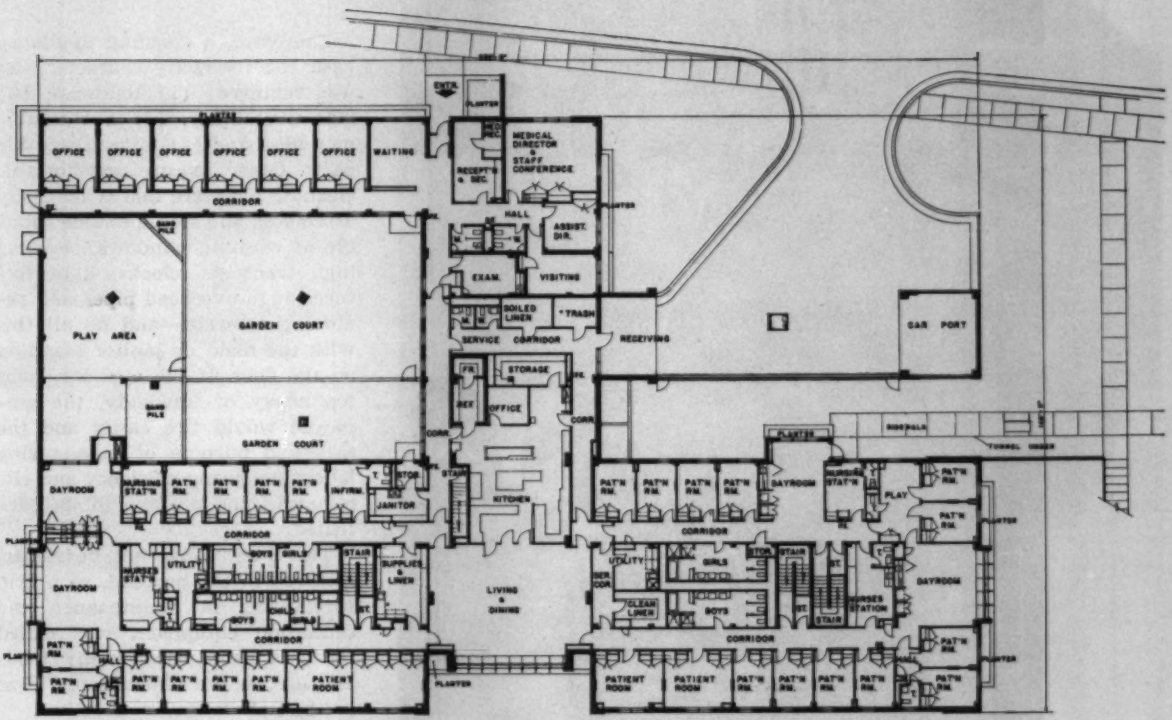

Fig. 2—Upper level, Children's Psychiatric Hospital, the Menninger Foundation, Topeka, Kan.

leaves 27,000 sq. ft. to be cleaned daily. The office wing, service areas, living and dining rooms, kitchen and all rooms on the lower level can be cleaned at night. The lower level areas (see Fig. 1) will be used for supervised play and the rooms will be relatively free from obstructions (furniture and fixtures).

SETTING CLEANING STANDARDS

The standard of cleaning required for the lower level areas will be lower than the standard to be maintained on the top level (see Fig. 2). One small janitor closet with mop sink on the lower level will provide adequate storage space for the supplies and equipment needed there. The top level areas to be cleaned at night will require a high standard of cleaning and, in order to save transportation time from the central janitor closet to the area, we plan to use one janitor cart. Two janitors should be able to clean these areas.

In the patient areas, all rooms and corridors will be cleaned during the day. The patient areas include approximately 9500 sq. ft. of floor space. From past experience, we know that one maid should be able to clean about 4000 sq. ft. of vinyl tile floor, make at least 12 beds and clean all rooms in the 4000 sq. ft. area (especially when the building is new). We estimate that the work equivalent of 2½ maids will be needed to clean this area. It is better to staff the area with as few persons as possible at the start, and add to the number if necessary, rather than to overstaff and later have to release someone, or let the employees develop poor work habits because of not having enough work to keep them busy.

In estimating the space requirements for a central janitor closet in the new building, if enough space is available we want to use a total of four carts, one for the night janitor and three for the day maids. Later, we may find we need to let the night employee use one of the day maid carts. We want to use carts in this building because the planned location of the central janitor closet would require passing through the combined living and dining room area to reach the right wing and walking through a relatively long corridor from both of the bed areas to the soiled linen room and the trash room.

The carts we plan to use are 54 in. long, 20 in. wide and 41 in. high, so we will need a space 7 by 5 ft. just to store four carts. We need floor space to store two mop bucket outfits, since with small children it is possible that we might need mop buckets in both wings at the same time. We anticipate that one floor scrubbing machine will be enough to take care of all machine scrubbing in this building, since we do not need to maintain a high standard of cleaning on any floors of the lower level. Shelves can be built on the wall above the carts for bulk supplies of toilet paper, paper towels, hand soap and other housekeeping supplies. We conclude then that, ideally, the janitor closet should contain approximately 100 sq. ft. The minimum space to operate economically would be around 84 sq. ft. and the absolute minimum to store housekeeping tools and supplies would be 70 sq. ft. ■

(Notes and Comment on page 104)

NOTES AND COMMENT

Imagination produces new housekeeping aid

by LUCILLE N. HALL

THE HOUSEKEEPING division at Veterans Administration Hospital, Hines, Ill., has a tremendous job of housekeeping to perform. A staff of 200 housekeeping employees, in this general medical and surgical hospital of 2100 beds, must establish and maintain clean and sanitary conditions in 55 buildings which contain 35 miles of corridors. Eleven-foot ceilings and eight-foot windows make this a formidable task. Compounding the job are the stairwells between floors, which have from 22 to 28 steps.

Since the housekeeping division is responsible for servicing an area of approximately 1.3 million square feet, and since one-fourth of the employees are off duty Monday through Friday, with a minimal staff on duty Saturday and Sunday, it became of paramount importance to initiate methods improvements that would save man hours, improve work performance and be acceptable to housekeeping personnel.

In addition, the great stress on safety and accident prevention by the administration, and the lack of adequate storage space in the hospital, meant that the housekeeping division had to eliminate the use of ladders from cleaning procedures.

Therefore, a cleaning appliance with the following characteristics was required: (1) lightness, (2) maneuverability, (3) a washable mop head and (4) interchangeable parts. Other requirements of this cleaning aid were that it be easily assembled and stored and be capable of washing windows, cleaning high transoms, clocks, light fixtures, high overhead pipes and removing cobwebs—and do all this with the maid or janitor standing on the floor. If the appliance was too heavy or unwieldy, the employee would tire easily and the threefold purpose of economizing labor, increasing efficiency and eliminating ladders would be defeated.

This item could not be manufactured in the hospital, so a firm specializing in maintenance and sanitation equipment was called for assistance. After many trials and errors, the "Dustmaster" was produced.*

The design combined four- and two-foot hollow, aluminum, extension tubes with a special ratchet to place the mop at any angle and a universal joint which permits the mop head to swivel freely. The washable dry mops are 12 inches long and are laundered with a special dust repellent, which makes this, in effect, a damp dusting technique. The "Dustmaster" has an assembly to wash windows, remove light bulbs, wash walls, clean and wax floors and sponge rugs.

The device was carefully tested on the training wards and evaluated. The maids and janitors liked its lightness and maneuverability. They also appreciated its versatility and were pleased that they did not have to climb up and down ladders to clean high objects and surfaces. They were also glad to be saved from the unnecessary fatigue caused by carrying ladders for long distances in order to complete their cleaning assignments.

Use of the "Dustmaster" has enabled the housekeeping staff to accomplish its threefold purpose of economizing labor, increasing efficiency and eliminating ladders. The most important feature, perhaps, is that using this device has removed the safety hazard inherent in the use of ladders. ■

*The name was furnished by the author.

Lucille N. Hall is chief, Housekeeping Division, Veterans Administration Hospital, Hines, Ill.

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Rise of the organization

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Law for physicians
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MODERN ORGANIZATION THEORY. Mason Haire, ed. New York, Wiley, 1959. 324 pp. $7.75.

Where does research stand in the study of organizations? What have been the results of studying organizations during the 1950's? *Modern Organization Theory* is a compilation of papers read at a symposium held by the Foundation for Research on Human Behavior at Ann Arbor, Mich., in February 1959. The aim of the symposium was to present the most recent thinking on the subject that has developed from many different investigations.

Most of the well-known names in organization theory—Bakke, Cyert, March, Rapoport, Argyris, Whyte, Likert, Cartwright—have contributed papers that in essence are a summary of their current thinking developed over the past decade. Some are papers on decision processes, others are concerned with the motivation of human beings. A few are concerned with the concept of the social organization, and still others with communication theory.

This book is not recommended for reading by the hospital executive who is looking for a ready answer to his problems. The concepts discussed in the book are sophisticated, the terminology difficult, and the relevance to operational situations is in many cases difficult to perceive. It is recommended reading for those in the hospital field who have not been aware of the tremendous development of research in the field of organization during the 1950's. It is an excellent book for learning where organization research now stands. One is impressed with the tremendous divergency of methods used in attempting to analyze organizations. On the other hand, it is disturbing to discover that there have been no research methods developed to explain the more complex parts and actions of organizations. Higher levels of the organization have been too long ignored in research studies. The papers in this volume indicate an awareness of such a need; if the next decade is as successful as the one just past, new dimensions of understanding should develop. It should be noted that the bibliography at the end of each chapter is a rather complete summary of the best papers written in the past ten years.—EVERETT A. JOHNSON, *administrator, Methodist Hospital of Gary, (Ind.).*

Law for physicians

THE LAW OF MEDICAL PRACTICE. Burke Shartel and Marcus L. Plant. Springfield, Ill., Thomas, 1959. 445 pp. $12.50.

The authors have undertaken, and achieved with considerable success, the ambitious objective of telling the practicing physician what he ought to know about the law applicable to his professional life. The writing is clear and nontechnical, and is enlivened with accounts of actual cases. A brief exposition of the legal process lays bare some of the law's professional mysteries.

The authors have not shunned controversial topics and in a few instances have frankly espoused unorthodoxy. In touching on major economic issues, however, they may be vulnerable to the charge of presenting the arguments of organized medicine both more sympathetically and more vigorously than the countervailing considerations.

Coverage of subject matter is comprehensive in scope but uneven in depth. The book's usefulness to hospital personnel—even to medical staff members—suffers from inadequate treatment of several common problems. Disclosure of confidential information is discussed without mention of third-party payors. Corporate practice receives scant attention. Most serious from the hospitals' standpoint, the treatment of hospital privileges overlooks the functions of the medical staff in the selection and discipline of its own membership and lacks the perspective afforded by an understanding of quality standards and the legal problems incidental to their enforcement. —ALANSON W. WILLCOX, *general counsel, American Hospital Association.*

Mental patient statistics

PATTERNS OF RETENTION, RELEASE, AND DEATH OF FIRST ADMISSIONS TO STATE MENTAL HOSPITALS. Earl S. Pollack and others. Washington, Government Printing Office, 1959. 53 pp. 40 cents (U.S. Public Health Service Publication No. 672).

Approximately 16 pages of this 53-page monograph are devoted to a discussion of methodology, objectives, interpretation, and conclusions. The remainder of the monograph consists of tables, graphs, and appendices.

Statistics included cover reports from 11 state hospital systems for a period of one year (1954). Essentially, they tell the story of what happens to first admissions during a 12-month period: terms of retention, release, and death for each of the 11 states reporting.

It is emphasized that this report cannot be used to compare therapeutic efficiency of the various state systems involved. For example, New York spent almost twice as much per patient, yet released only 40 per cent within a year. Louisiana, on the other hand, released about 70 per cent within a year.

Unfortunately, the conclusions are more valuable from a negative standpoint rather than from a positive one. A need for more careful interpretation of interstate differences rather than giving only the traditional comparison of mental hospital release rates is indicated.

This monograph may be of interest to state hospital administrators, but perhaps of even more interest to sociologists concerned with assessing the relationship between state hospitals and their social and political milieu.—E. P. PETERSON, M.D., *clinical director, Eastern State Hospital, Medical Lake, Wash.*

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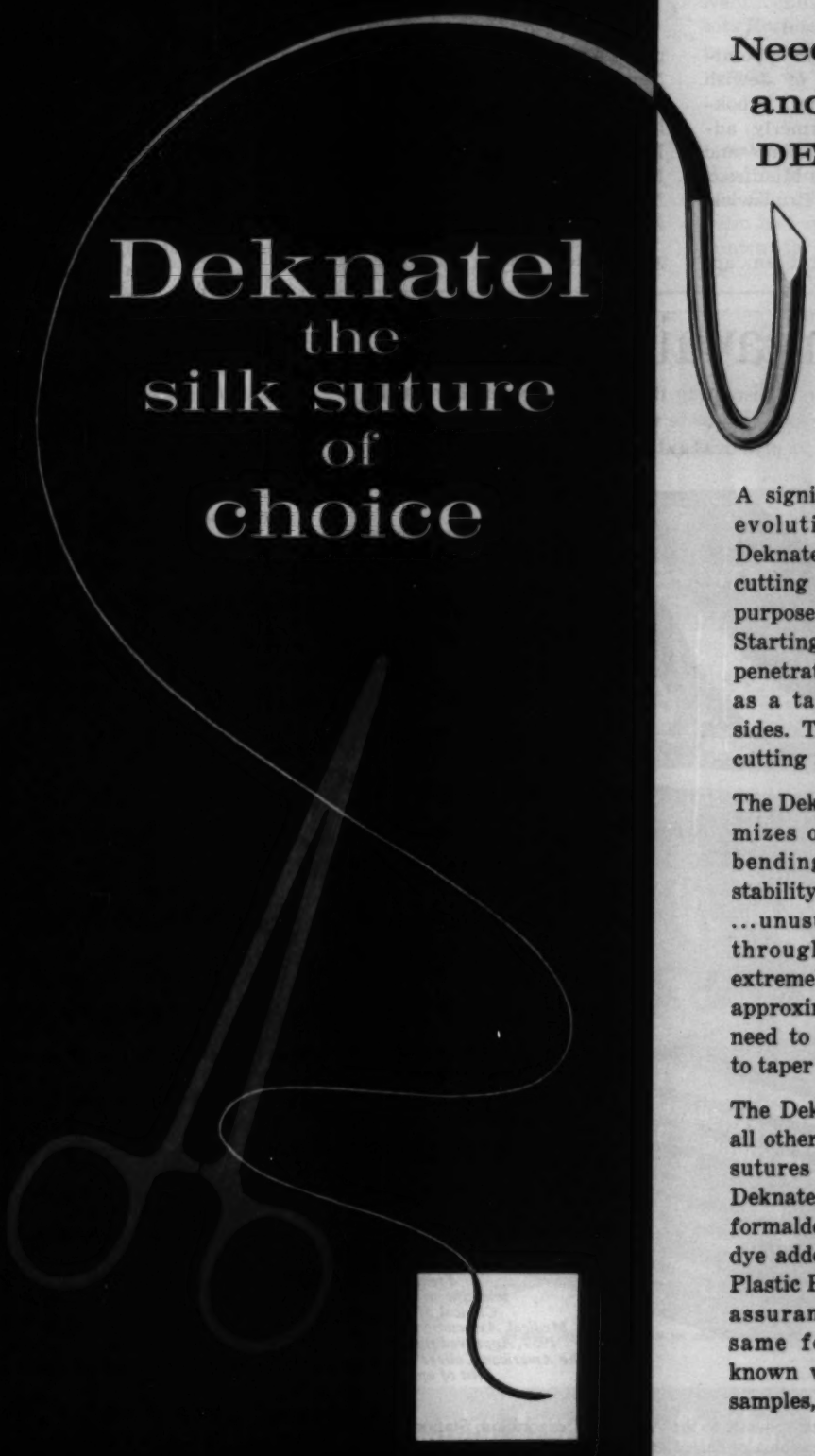

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personnel changes

● **John H. Beddow** has been appointed executive director of Jewish Chronic Disease Hospital, Brooklyn, N.Y. He was formerly administrative vice president and general manager of the Middlesex General Hospital, New Brunswick, N.J.

● **Richard F. Binnig** has been appointed assistant director of Grace-New Haven Community Hospital, New Haven, Conn. He was formerly assistant administrator of Ball Memorial Hospital, Muncie, Ind. Mr. Binnig is a graduate of the Northwestern University program in hospital administration.

● **Mary Ruth Bruenig** has been appointed administrator of Arlington (Tex.) Memorial Hospital. She was formerly acting administrator of the hospital. Mrs. Bruenig succeeds **Alma Webb** who resigned.

● **Keith E. Calvert** has been appointed administrator of Okfuskee Memorial Hospital, Okemah, Okla., succeeding **Leon Gordon** who resigned to accept the position of administrator of McCurtain Memorial Hospital, Idabel, Okla. Mr. Calvert was formerly chief medical technologist at Municipal Hospital, Stillwater, Okla.

● **Comdr. A. P. Chartier, MSC, USN,** has been appointed administrative officer and aide to the commanding officer of the National Naval Medical Center, Bethesda, Md. He succeeds **Lt. R. J. Hanavan, MSC, USN.**

COMDR. CHARTIER

Comdr. Chartier was formerly executive assistant for administration to the commanding officer of the U. S. Naval Hospital at the medical center.

Lt. Hanavan has been assigned as administrative assistant to the senior medical officer, U.S. Naval Shipyard, Pearl Harbor, Hawaii.

● **Lawrence C. Davis Jr.,** has been appointed assistant administrator of Hackensack (N.J.) Hospital. He was formerly administrative assistant at that hospital. Mr. Davis is a graduate of the Northwestern University program in hospital administration.

● **Paul F. Detrick** has been appointed administrator of Christian Hospital, St. Louis. He has been a hospital consultant since 1959, and prior to that time was administrator of Freeman Hospital, Joplin, Mo. Mr. Detrick is a graduate of the Northwestern University program in hospital administration.

● **John M. Duggan** has been appointed administrator of Astoria

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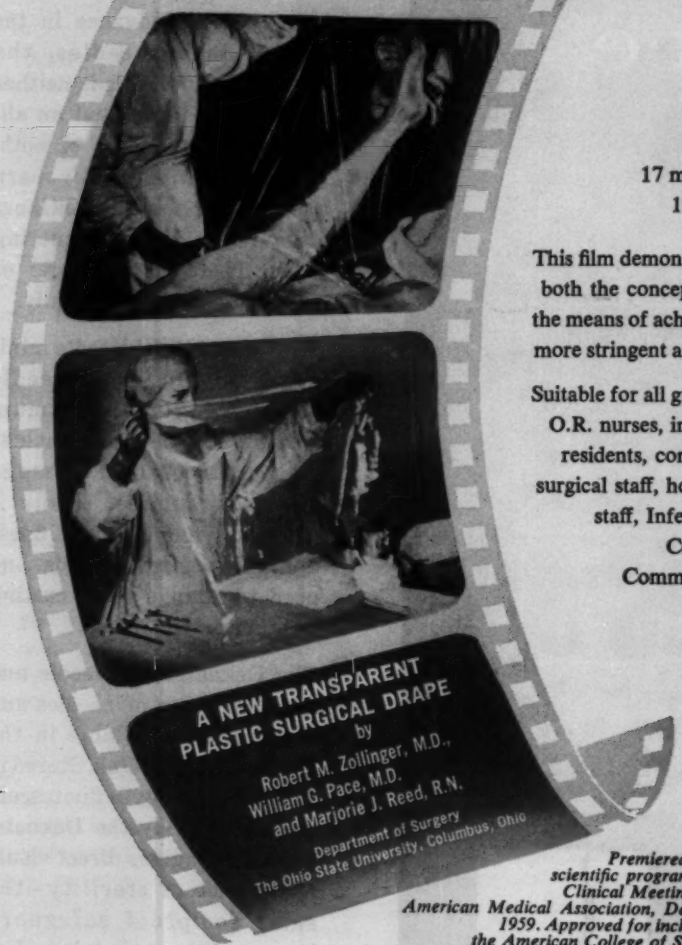

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(L.I., N.Y.) General Hospital. He was formerly assistant administrator of Misericordia Hospital in the Bronx, N.Y., as well as assistant director of planning for the hospital in its move from Manhattan to the Bronx.

● **Leon Gordon** (see Keith E. Calvert item).

● **Lt. R. J. Hanavan, MSC, USN** (see Comdr. A. P. Chartier item).

● **Robert R. Hencye** has been appointed administrator of Delta (Colo.) Memorial Hospital. He was formerly assistant administrator of Montrose (Colo.) Memorial Hospital.

● **Asahel H. Jeffers** has been appointed administrator of Lawrence County Hospital, Lawrenceburg, Tenn. He was formerly administrator of Bacon County Hospital, Alma, Ga. Mr. Jeffers is a graduate of the Georgia State College program in hospital administration. He succeeds **John A. Maloney** who has been appointed administrator of Morristown-Hamblen Hospital, Morristown, Tenn. Mr. Maloney is also a graduate of the Georgia State College program in hospital administration, and succeeds **William G. Messer.**

● **Dean E. Leiser** and **Jack C. Robinette** have been appointed assistant administrators of Ohio State University Health Center, Columbus. Both are graduates of the University of Chicago program in hospital administration and were formerly administrative assistants at the center.

● **John A. Maloney** (see Asahel H. Jeffers item).

● **Helen J. Mapps** has been appointed administrator of Monte Vista (Colo.) Community Hospital. Miss Mapps was administrator of the St. Vrain Hospital Association, Longmont, Colo., for approximately 11 years, until the institution closed. Miss Mapps is a graduate of Colorado State College, Ft. Collins, Colo.

● **William G. Messer** (see Asahel H. Jeffers item).

● **Roy F. Myers** has been appointed administrator of General Hospital, Greenville, Miss. Having joined that institution in 1956, he served in turn as business manager, assistant administrator, and acting administrator. Mr. Myers holds a B.S. degree in accounting from New York University.

● **Jack C. Robinette** (see Dean E. Leiser item).

● **Alma Webb** (see Mary Ruth Bruenig item).

● **Byron N. Whitford** has been appointed director of Doctors Hospital, Michigan City, Ind. He was formerly an administrative assistant at Clarkson Hospital, Omaha, Nebr., and administrator of Doctors Hospital, Omaha. Mr. Whitford is a graduate of Washington University, St. Louis.

Deaths

Mabel Selin, R.N., administrator of Hardin Memorial Hospital, Kenton, Ohio, died February 23. Miss Selin had served as a hospital administrator in northwestern Ohio for 25 years.

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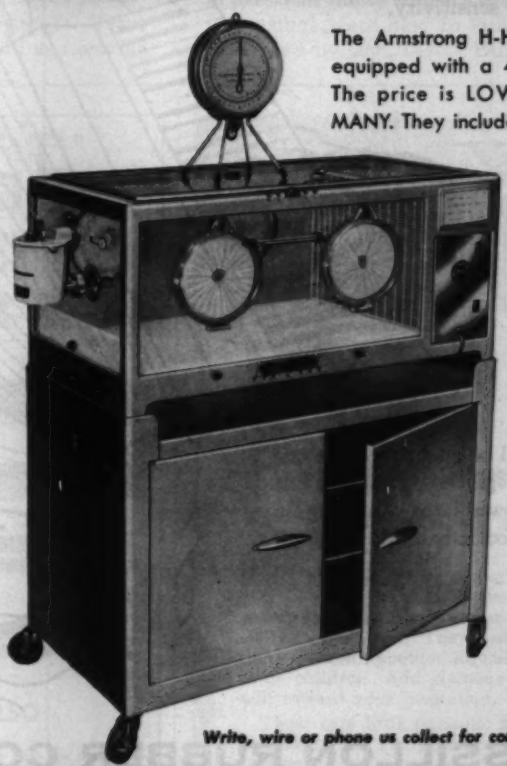
Hand-hole type Baby Incubator



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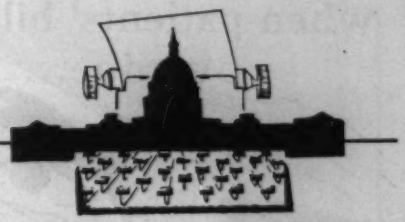

Aged Health Care Issue Nears Climax

Congress this month entered its final weeks of decisions on many health and hospital bills. A major item still unresolved was the program of health care for aged persons. Key members of the House and Senate anticipated that the issue may finally be put to a show-down vote this month in the House Ways and Means Committee.

It appeared possible that democratic leaders would succeed in putting through the committee some compromise plan giving the aged a choice between higher cash benefits and hospitalization insurance under the social security program.

Benefits might be limited to persons 72 years of age or older in order to hold to a maximum of $12 a year the boost in combined employer-employee payroll taxes required to finance the program. The administration opposed this approach. Both democratic majority leader Sen. Lyndon Johnson (D-Tex.) and President Eisenhower went on record as favoring some kind of federal program to aid the aged in paying their health bills.

The President said at an April press conference that he was preparing a message for Congress which would include a bill on health care for the aged. The only thing to which he said he was "utterly opposed" was the use of " . . . compulsory insurance in this field and placing the matter in the OASI by adding on a half per cent of taxes . . . . "

Senator Johnson promised in two recent speeches to put a democratic proposal on the President's desk before Congress adjourned.

Hearings Held on Practical Nurse Legislation

Congress has taken the first steps in the legislative process to extend for another four years federal aid to practical nurse education.

Hearings were held in late April on identical bills sponsored by Sen. Lister Hill (D-Ala.), chairman of

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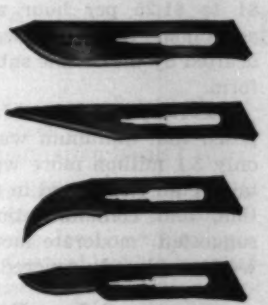

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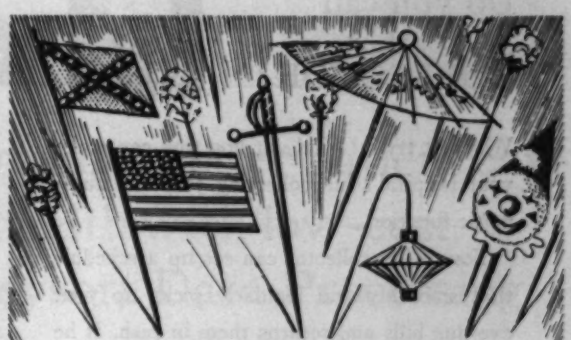

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the Senate Labor and Public Welfare Committee and Rep. Carl Elliott (D-Ala.), chairman of the Special Education Subcommittee of the House Education and Labor Committee.

The bills not only extend authority for the federal program beyond its 1961 expiration date, but also remove from the law a restriction that federal funds be used only to "extend and improve" state practical nurse training. With the restriction removed, states could use federal money also for their older, already established programs.

At the opening session of the house subcommittee hearings a statement sent by Donald G. Harms, president of the Alabama Hospital Association was heard. In it Mr. Harms endorsed the extension and noted that "the shortage of trained personnel to provide nursing service is increasing each year".

Elizabeth E. Kerr, a representative of the American Vocational Association, reported to the subcommittee that of 632 approved schools for practical nurse training 432 now receive federal support. Miss Kerr said, "It will be necessary not only to maintain the existing programs but to enlarge these when possible and establish additional practical nurse training programs."

The Administration this year withdrew its earlier suggestion that federal financial aid to practical nurse training be tapered off. The Eisenhower budget for fiscal 1961 requested $4 million in federal funds, the same as the 1960 appropriation.

Minimum Wage Bill Interpreted to Exclude Charitable Organizations

Legislative proposals to extend minimum wage coverage are being scaled down.

A bill sponsored by Sen. John F. Kennedy (D-Mass.), chairman of the Labor Subcommittee of the Senate Labor and Public Welfare Committee, has been interpreted by the U.S. Department of Labor as not affecting nonprofit or charitable organizations since they are not engaged in common business.

The Kennedy bill to raise minimum wages from $1 to $1.25 per hour and extend coverage to an additional seven million workers was being redrafted by the Senate subcommittee to a more limited form.

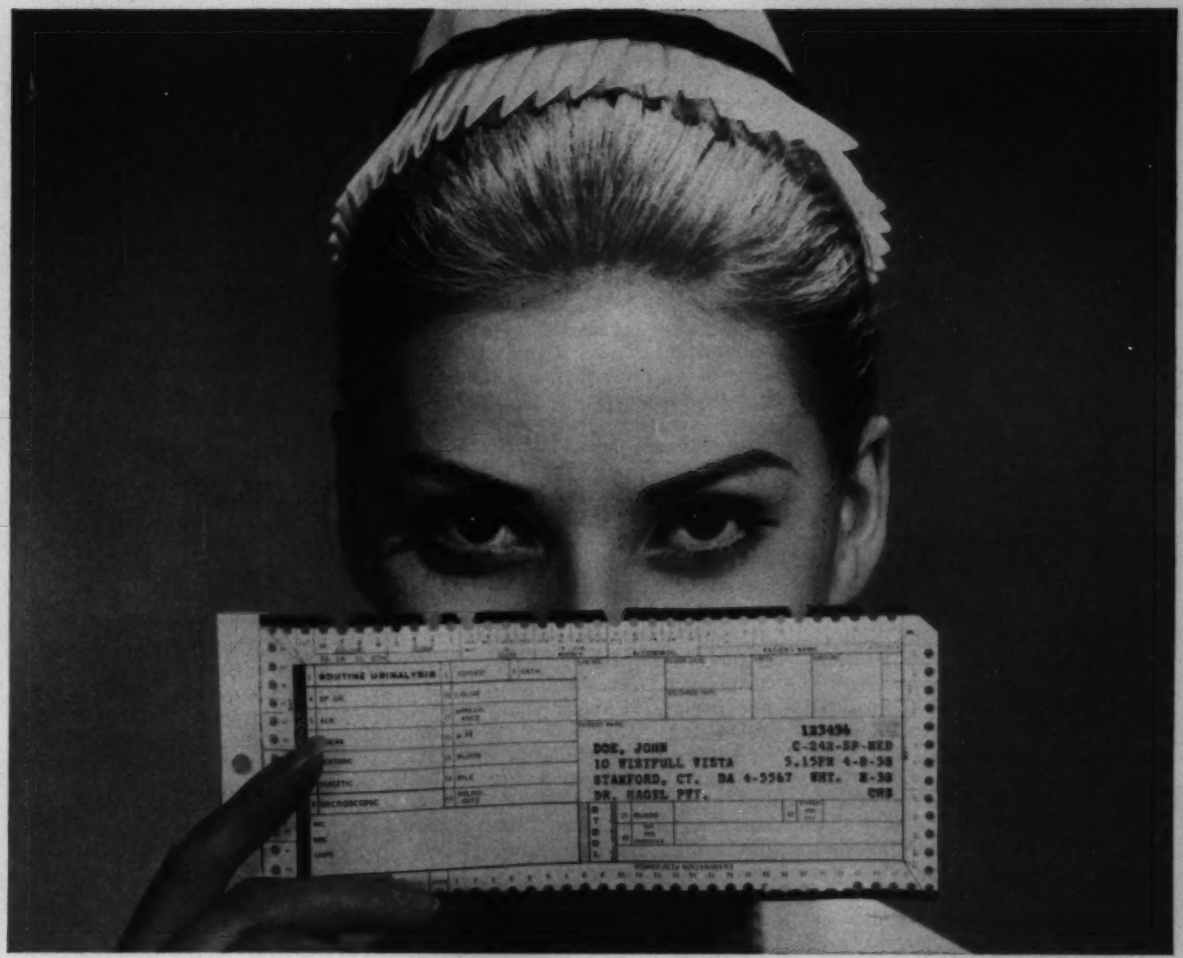
Secretary of Labor James P. Mitchell has proposed that minimum wage coverage be extended to only 3.1 million more workers, mainly those in certain retail trades and in the construction, transportation, and communication industries. Mr. Mitchell suggested "moderate increases" to $1.10 or $1.15 for workers already covered.

Salary Rise Proposed for VA Hospital Executives

Congress has been moving forward in yet another area of interest to hospitals. Legislation to raise the salaries of Veterans Administration hospital executives and to accelerate the patient turnover rate in VA hospitals has been recommended by the House Veterans Affairs Committee.

A committee bill would fix at $16,500 the annual

(Continued on page 125)



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NEW CONCEPTS IN PRACTICAL OFFICE AUTOMATION

AT A NEW YORK MEETING—

Short Stays No Panacea, Panelist Says; Improved Planning Is Urged

The average cost per stay remains the same despite reduction in the average length of stay—if a hospital is unable to increase its admissions or decrease its expenses. This was the contention of one of the panelists participating in a discussion of utilization of hospital facilities held for members of the Greater New York Hospital Association.

The speaker, Charles G. Roswell, director of hospital services division of United Hospital Fund of New York, debated the hospital utilization and cost control problem from the financial and actuarial point of view. Along with him on the panel was a spokesman for the public, Martin E. Segal, president of Martin E. Segal and Co., Inc. consultants in industrial pension and welfare funds; David Kershner, M.D., chairman of a medical society committee cooperating with the hospital association, and William A. Kelly, M.D., director of Mount Vernon (N.Y.) Hospital.

The panel was held as part of a joint endeavor of hospital and medical groups to deal with the problem of rising hospital costs. That concerted effort began last September with the formal announcement by GNYHA of a program "designed to effect a net saving in hospital costs for the community through intensification of the use of hospital facilities to reduce the amount of inpatient hospital care".

INTERPLAY OF THREE FACTORS

Mr. Roswell based his remarks concerning the financial aspects of utilization on data reported by one of New York's large general hospitals. It is quite conceivable, he said, that in many instances reduction in the average length of stay will not be accompanied by an increase in admissions, and operating expenses will not necessarily be reduced as a result of shorter hospitalization.

Mr. Roswell declared that if the average patient stay decreases from 10 to 8 days (20 per cent), admissions would have to be increased or expenditures decreased by 25 per cent. The cost per stay remains the same if a hospital is unable to increase its admissions or decrease its expenses, even though the average length of stay is shortened, Mr. Roswell maintained. Consequently, the public and third party agencies would be reimbursing hospitals for fewer days but at a higher per diem charge; the over-all cost per case would remain the same, he stated.

Mr. Roswell illustrated his point by calculating what would happen if the length of stay for the group hospitalized for the longest average period, 17 days, was reduced to 14 days. This reduction would be sufficient to reduce the over-all average from 10 to 9 days. With the same number of admissions and the same expenses, the cost per day would increase from $34.50, the present patient day cost in the reporting hospital, to $38.50. The short-stay case (three days), calculated at a per diem reimbursement rate, would cost 12 per cent more, as would the medium-long case (10 days). Only the cost for the long-stay case would be reduced, by 9 per cent.

NEEDED: 'PUBLIC SERVICE' FACE

The public's misunderstanding of and dissatisfaction with hospital costs was discussed by Mr. Segal. The public's criticism could be attributed to three factors, he said:

1. Insufficient hospital activity to acquire a "public service" face rather than a "business" face.
2. Hospitals' failure to combine their efforts toward activity that would improve the quality of care and control or modify costs.
3. Hospitals' failure to recognize the importance of third party groups in the financing of hospital care.

To remedy the situation, Mr. Segal said hospitals should:

- Share special equipment.
- Participate in joint purchasing.
- Use beds more effectively.
- Use professional and institutional personnel more effectively.
- Use uniform accounting methods and systems.
- Participate in regional and community planning of facilities to eliminate unnecessary duplication.
- Make more extensive use of outpatient clinics.
- Strive for closer and more disciplined relationship with the medical profession and for establishment of utilization committees in all hospitals.
- Educate the public through publicity as to the difference between operating an ordinary business and a hospital.

The spokesman for the medical societies, Dr. Kershner, agreed with Mr. Segal on several points. He argued for the establishment of utilization control committees in all hospitals and for more extensive use of outpatient departments for diagnostic services. ■

OHIO ADMINISTRATORS TOLD—

Maintain Quality Regardless of Cost

"Let us not lose our nerve about rising costs and allow the quality of patient care to deteriorate." This statement by Ray E. Brown, superintendent of the University of Chicago Clinics, capsuled the opinions expressed by many of the speakers at the annual convention of the Ohio Hospital Association April 4-7 in Columbus. Mr. Brown, who delivered the opening address at the meeting, said also that the largest problem facing hospital trustees and administrators today was that of lethargy, or the inertia, of the public.

"People now expect others to keep them informed," he said, "rather than going out and seeking information for themselves, and there is keen competition for public attention." He added that the public may allow hospitals to "go overboard" simply because of this inertia—the unwillingness of the people to find out the facts for themselves and study them.

This attitude, he said, intensifies the need for hospitals to make strong efforts to gain the public's attention—overcoming the compe-

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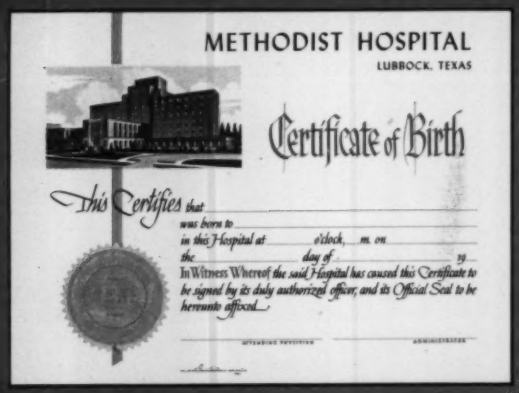
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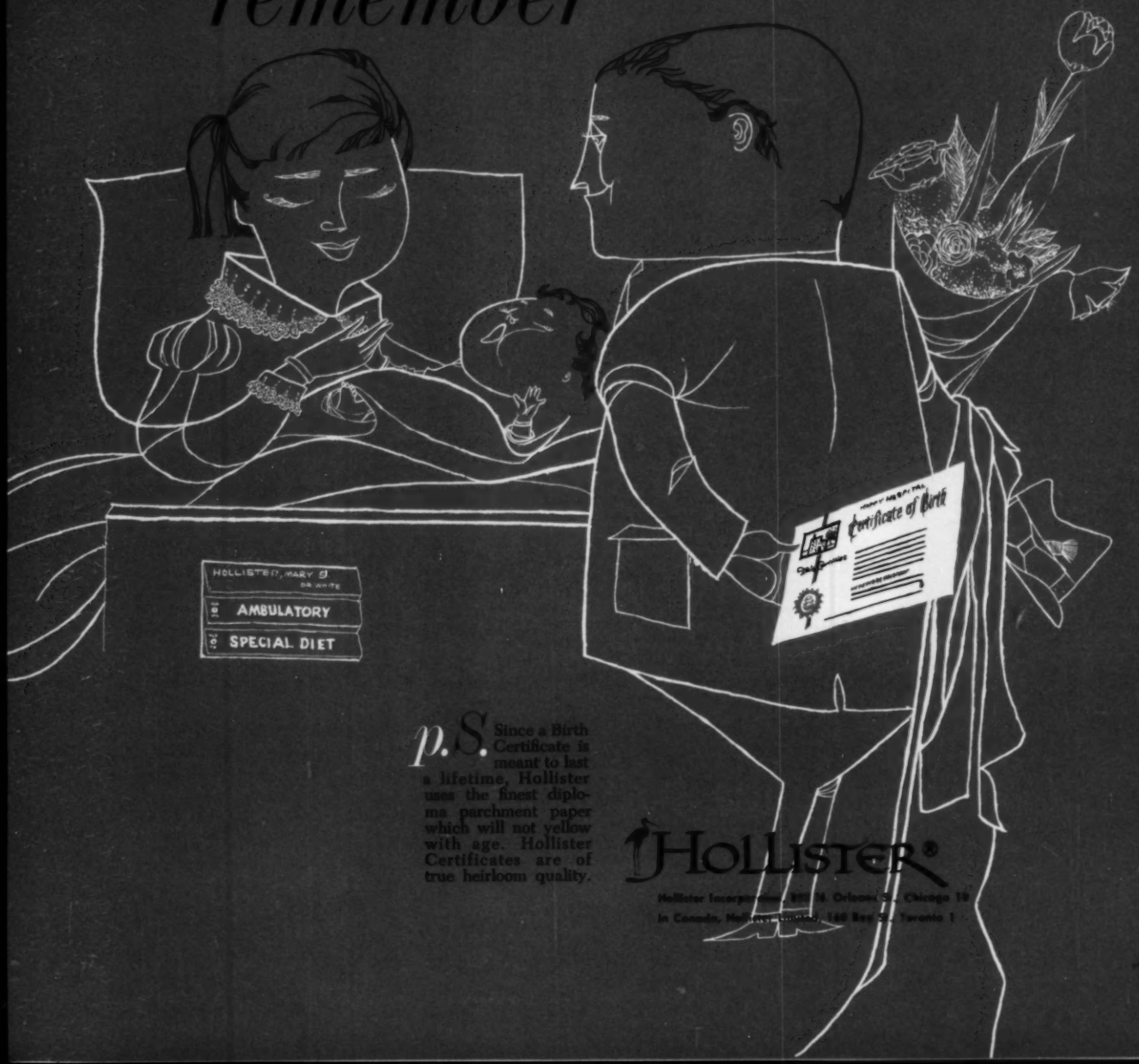

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tition for attention provided by newspapers, magazines and television—to interpret hospital facts and costs in a manner that will capture public interest and concern.

WAGES VS. CARE QUALITY

Concurrence with the viewpoint that good patient care, not costs, should be the hospital's first consideration was evident in talks stressing the need for more equitable wages and sound personnel policies for hospital employees. Sidney Lewine, director of Mount Sinai Hospital, Cleveland, said, "What right has the hospital board or the community to expect the administrator to do an effective job in providing good patient care [when he is forced to] pay lower wages to employees than they could receive in comparable jobs elsewhere in the community?" To pay less than industry, Mr. Lewine continued, is to say to the employee "you subsidize our hospitals". "It is time," he said, "that we as mature hospital administrators in a mature management field recognize our responsibility to match the salary scales and personnel practices of the community."

UNIONS IMPOSE RESTRICTIONS

William I. Christopher, director of hospital personnel services of the Catholic Hospital Association, the second speaker at this session, warned hospital administrators that restrictions would be imposed on them through unionization if they failed to implement "good and decent personnel practices".

Mr. Christopher further said that hospitals need to concentrate on basic management, since without this there can be no good personnel management. Competent management will instill confidence in management practices and achieve a sense of security for the worker, he said. ■

IN NEW YORK STATE—

Hospital Group Seeks Degree Granting Rights for Hospital Nursing Schools

Degree-granting rights for hospital schools of nursing are being sought by the Hospital Association of New York State. In a proposal submitted to the committee on higher and professional education and committee on charters of the Board of Regents of the New York State Education Department, the association requested that "hospital schools of nursing be authorized to grant an associate degree in nursing to the graduates of approved three-year schools of nursing".

The proposal had been prepared by the board of trustees and the committee on nursing service of the hospital association. The continuing nursing shortage and the need to increase the number of students entering nursing schools were given as the primary reasons for the proposal. The association pointed out that no additional expenditures would be incurred by student nurses, hospitals or the state's taxpayers if the plan were approved.

The arguments advanced by HANYS in favor of the proposal fell into two main categories: One illustrated why degree granting by hospital schools of nursing would produce more nurses; the other gave educational justifications for the proposal.

Along the first line of reasoning, the association pointed out that:

- The average mortality for hospital schools is 33 per cent, compared with 66 per cent in collegiate schools of nursing, and graduates of hospital schools are more inclined to go into hospital nursing after completing their courses.
- Increasing emphasis is being placed on the benefits and advantages of higher education. Consequently, high school graduates and high school counselors favor degree-granting institutions. If hospital schools could grant degrees, more graduates interested in nursing careers would choose these schools, and counselors would be more willing to direct students to them.
- Because the cost of obtaining nursing education in hospital schools is considerably lower, girls whose parents cannot afford the cost of a college tuition would be able to obtain an associate degree from a hospital school.
- Married graduates of hospital schools of nursing who have left their profession to raise a family would find it comparatively easy to return to work, because they had been thoroughly trained in nursing skills and arts by the time of their graduation.

In presenting the educational merits of its proposal, the hospital association stated that the total number of hours of supervised instruction in a three-year hospital program is nearly twice that given the average college student in four years, and possibly four times the instruction hours given in a two-year community college granting

OHIO HOSPITAL ASSOCIATION OFFICERS were elected last month at the group's annual meeting, held in Columbus. They are, sitting: (left to right) chairman, Southwestern District, Sister Eugene Marie, administrator, Good Samaritan Hospital, Cincinnati; president, John C. Gettman, administrator, Memorial Hospital, Fremont; president-elect, Harold A. Zealley, administrator, Elyria Memorial Hospital. Standing: chairman, Northwestern District, James E. Moss, administrator, Riverside Hospital, Toledo; first vice president, Edgar O. Mansfield, superintendent, White Cross Hospital, Columbus. Not included in this photograph were second vice president, Sister Marie Charles, administrator, Good Samaritan Hospital, Dayton, and treasurer, Lee S. Lanpher, administrator, Lutheran Hospital, Cleveland.

an associate degree.

In summing up the educational arguments, the association said it believed "that the course content of the approved three-year diploma school of nursing is the equivalent of two years of collegiate preparation . . ."

Association officials said they have received assurances from the Board of Regents and the State Education Department that the proposal was being given serious consideration. ■

Hospital Training Required for Future AAGP Members

After January 1, 1966, two years of hospital training will be required of all applicants for membership in the American Academy of General Practice. This provision was written into the constitution and bylaws of the AAGP after it was approved by the Congress of Delegates of the Academy during its 12th Annual Scientific Assembly held in Philadelphia in late March.

The delegates also went on record as favoring the continuance in departmentalized hospitals of separate general practice departments to conduct their own clinical reviews. This resolution was proposed by the Reference Committee on Hospitals of the AAGP.

Although no definite action was taken concerning mandatory hospital training in obstetrics and surgery, the delegates indicated that they favored such training. They adopted a recommendation from the Reference Committee on Education asking each state chapter to encourage American Medical Association delegates to support a change in requirements for the newly established two-year family practice program to make training in obstetrics and surgery mandatory. The program was approved in June 1959 by the AMA House of Delegates and is currently being established in carefully chosen hospitals. It does not include mandatory training in obstetrics or surgery, but does offer obstetrics on an elective basis. Medical school graduates enter the family program immediately after graduation.

The AAGP delegates also:

- Called attention to the need for greater participation by physicians in hospital management.
- Endorsed the establishment of a special ad hoc committee which will (a) undertake a study of the public image and confusion regarding the family physician; (b) establish liaison with the American Medical Association, the American Hospital Association and the American College of Physicians, and (c) outline a program to eliminate the public's confusion as to who is the family physician. ■

New York Blue Cross Asks 37.3 Per Cent Rate Increase

A rate increase averaging 37.3 per cent has been requested of New York State Superintendent of Insurance by Associated Hospital Service of New York, the Blue Cross Plan operating in New York City and 12 neighboring counties. The petition asked that the rate change become effective October 1.

The cost of additional benefits would absorb approximately 7 per cent of the 37.3 per cent increase, the Plan said. The remainder will be needed mainly to meet "the basic trend in increased hospital utilization and costs".

The following added coverage would be provided under the Plan's 21-day contract: Infants from birth; persons with mental or nervous disorders, 21 full benefit days and 9 discount days; cosmetic surgery. Allowance for private rooms would be raised.

Added benefits under the 120-day contract would include: Coverage of infants from birth; a $150 allowance for non-Caesarian maternity hospitalization, with additional maternity benefits in special cases; an allowance toward private accommodations equal to semi-private charge (in nonmember hospitals, that allowance would be set at $16 a day). Payments for up to 30 days of hospitalization each year would be made for persons with pulmonary tubercular disorders or mental or nervous disorders. The daily payment would be $10 for hospitalization in a tuberculosis or a psychiatric hospital.

The proposed rate increase would bring the monthly premium from $6.60 to $9 for a 21-day family group contract; this increase would be from $8.89 to $11.88 for the 120-day contract.

Comparable increases would apply for individual policies under group coverage and for all direct-pay contracts. ■

Brockton VA Hospital Wins 1959 Hospital Safety Contest

The Veterans Administration Hospital at Brockton, Mass., has been named grand award winner of the 1959 Hospital Safety Contest sponsored by the American Hospital Association and the National Safety Council.

Designed to encourage the observance of safety practices among hospital employees, the contest was judged on the basis of the lowest number of injuries among hospital employees in relation to the number of man-hours worked during the year.

Of the 299 competing hospitals, 32 completed the contest with perfect records, operating over 7 million injury-free man-hours. The Brockton hospital, with more than 1100 employees, worked 2,319,544 man-hours without an injury.

Hospitals taking part in the contest were divided into eight groups according to the number of employees. Winners of first place plaques in each group were:

- Fewer than 100 employees—Memorial Hospital, Carthage, Ill.
- 100-199 employees—Cherokee County Memorial Hospital, Gaffney, S.C.
- 200-299 employees—Latrobe (Pa.) Hospital.
- 300-499 employees—Doctors Hospital, Cleveland Heights, Ohio.
- 450-599 employees—Alexandria (Va.) Hospital.
- 600-799 employees—Queens Hospital, Honolulu, Hawaii.
- 800-999 employees—Veterans Administration Hospital, Sepulveda, Calif.
- 1000 or more employees—Valley Forge Army Hospital, Phoenixville, Pa. ■

Newspaper Campaign Features Hospital Trustees

A state-wide newspaper advertising campaign intended to reassure the public of hospital integrity was sponsored this month by the Hospital Council of Maryland. It was timed to coincide with the National Hospital Week.

The campaign was keyed around the role of hospital trustees, and was made possible by their overwhelming support. The advertisements, which appeared May 8 and 9 in all Maryland newspapers, carried in the center of the page a "Trustees Code". The code was surrounded by signatures obtained throughout the state from trustees. The signatures were secured by means of a self-addressed post card sent to the trustees by the hospital council. They were requested to sign the code printed on the card and return the card so that their signatures could be used in the advertisements. The name of the hospital was filled in under the

PIONEER on Every Hospital Hand

In addition to its long-life line of Rollpruf Surgical Gloves, Pioneer makes other glove styles, weights and materials to protect every hand at work in your hospital. Your Pioneer Glove Expert can show you new ways to achieve maximum glove economy by using the complete Pioneer Hospital Glove Line. The coupon at right entitles your hospital to a free Glove Handling Analysis by Pioneer experts, to insure the efficiency of your glove usage.

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Title_____

_____ Hospital

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trustee's signature. The code read:

"We the Trustees of Maryland Hospitals affirm that our institutions are dedicated solely to the care of the sick and injured, and do solemnly pledge to the people of this state that those received into our hospitals shall be given the best care we can provide . . . selflessly, and as efficiently as possible."

The slogan "Hospital Care—A Community Trust" appeared prominently in the advertisement; also included was copy tying the ad in with National Hospital Week.

In a letter requesting the trustees to sign the enclosed "code card", the hospital council explained the need for the campaign by saying: "Rising hospital costs with the attendant Blue Cross rate increases have nourished doubt and uncertainty in many minds concerning the efficiency of hospitals . . . and even their integrity . . . The publication of the code to the people of Maryland will do much to reassure them about their hospitals . . ."

The education of the public as to hospital costs will continue, the council said, but at this time a public restatement of the "basic community trust of a voluntary hospital" should be helpful in reassuring the public of hospital integrity. The letter to the trustees was signed by the chairman of the trustee section of the hospital council. Approximately 700 of the state's more than 800 hospital trustees returned the signed cards by specified deadline, the council reported. ■

Ruth Kahn Made Supervisor for Food Service Firm

Ruth M. Kahn has been appointed regional supervisor for Hospital Food Management, an affiliate of Slater Food Service Management, which operates dietary departments of 30 hospitals in 12 states. She will join the new Western Region offices of Slater, in Los Angeles, on June 1.

MISS KAHN

A staff representative in the Department of Professional Services of the American Hospital Association since 1956, Miss Kahn was director of dietetics and of the dietetic internship program at Michael Reese Hospital, Chicago, for six years, and prior to that chief dietitian at Veterans Administration Hospital, Hines, Ill. She organized food service in displaced persons camps and hospitals for UNRRA in Germany after World War II.

Miss Kahn has a B.S. degree in foods and nutrition from the University of Illinois, and an M.S. degree in experimental foods from the University of Chicago. She is past secretary of the American Dietetic Association, and past president of Missouri, Illinois, Chicago and St. Louis Dietetic Associations. She served her dietetic internship at Barnes Hospital, St. Louis, where she was administrative dietitian. ■

APhA Names Oddis Hospital Pharmacy Director

Joseph A. Oddis, has been appointed director of the American Pharmaceutical Association's Division of Hospital Pharmacy, Washington D.C., effective June 1. Mr. Oddis will also serve as assistant secretary of the American Society of Hospital Pharmacists, APhA said.

MR. ODDIS

Since 1956 Mr. Oddis has been a staff representative in the Department of Professional Services of the American Hospital Association. Before joining the AHA, Mr. Oddis was chief pharmacist at Western Pennsylvania Hospital, Pittsburgh, and prior to that served as staff pharmacist at Mercy Hospital, also in Pittsburgh. A graduate of Duquesne University, Pittsburgh, Mr. Oddis has served as vice president of Illinois Society of Hospital Pharmacists and as president of Western Pennsylvania Society of Hospital Pharmacists. ■

Philadelphia Association and Council Announce Merger

The Hospital Council of Philadelphia and the Philadelphia Hospital Association merged last month into one organization, the Delaware Valley Hospital Council. The merger had been under consideration since summer of 1959, and a constitution and bylaws of the new council were drafted and approved earlier this year.

The board of directors of the Delaware Valley Hospital Council will consist of 18 elected members, of whom 10 must be voluntary trustees of member hospitals and 8 administrators of member hospitals.

The president and vice president of the council must be trustees, the secretary-treasurer an administrator.

In addition to the board, provision was made for the creation of a forum. The forum will be composed of hospital administrative, governing board and medical staff personnel, and will also include persons associated with related health organizations. The forum will have its own elected officers, dues and committees.

Two new standing committees were provided in the new council's bylaws: a standing committee to assist hospital planning and a standing committee on public information and public relations. ■

Benefits Paid by Insurance Double in Five Year Period

Voluntary health insurance paid $3.1 billion in benefits during a 12 month 1957-1958 period. This was more than double the amount paid in a similar period five years earlier. This information was contained in the third of a series of preliminary reports on a study made by the Health Information Foundation in cooperation with the National Opinion Research Center of the University of Chicago.

In connection with the study, a representative cross section of American families were interviewed about the kinds of medical services they use and the way they pay for them.

The average insured family in 1957-1958 received $80 in benefits from voluntary health plans, HIF reported. This was a 78 per cent increase over the $45 reported in a comparable 1952-1953 survey.

According to George Bugbee, president of the foundation, one of the most significant findings of the survey was that families with unusually heavy health care costs were helped the most by recent increases in insurance benefits. For example, families with health costs of $1000 and more averaged $572 in benefits for 1957-1958, against only $362 in 1952-1953. Families with costs between $750 and $1000 received $257 in benefits, while comparable families received only $204 in 1952-1953.

Mr. Bugbee noted, however, that voluntary health insurance should be improved further. He supported this argument by citing that only

24 per cent of families with annual expenses of $500 or more had 50 per cent or more of their total bill reimbursed by insurance in 1957-1958. ■

New List of Short Courses for Nurses Given by PHS

The first supplemental list of agencies sponsoring federally-supported short-term courses for nurse administrators, supervisors, and teachers has been issued by the U.S. Public Health Service. (The initial list of agencies sponsoring courses appeared in the April 1 issue of this Journal.)

The following additions have been announced.

School of Nursing, Medical College of Georgia, Augusta, Ga. Director: Miss Alda L. Ditchfield, professor. Subject: Administration of Nursing Services in Smaller Community Hospitals. Dates: May 23 through 27.

Department of Nurse Education, School of Education, New York University, New York 3. Director: Miss Jane Hoexter, associate professor of education. Subject: Changing Concepts in the Teaching of Public Health Nursing Clinical Practice. Dates: May 23-27, 1960.

Department of Nursing Education, Teachers College, Columbia University, New York 27. Four courses: (1) Director: Miss Frances R. Kreuter, professor. Subject: Nursing Practicum in Chronic Disease and Aging. Dates: June 13 through 24. (2) Director: Miss Lutie C. Leavell, professor. Subject: Work Conference on Improving Nursing Care Through Application of Science Principles. Dates: May 30 through June 10. (3) Director: Miss Barbara Tate. Subject: Workshop on Evaluation of Nursing Performance of Students by Clinical Supervisor. Dates: May 23 through 27; repeated October 24 through 28. (4) Director: Miss Barbara Tate. Subject: Workshop on Evaluation of Nursing Performance of Staff Nurses by In-Service Educational Supervisor. Dates: June 6 through 10; repeated November 14 through 18.

School of Nursing, University of Michigan, Ann Arbor. Two courses: (1) Director: Miss Theresa Phelps, assistant professor of nursing. Subject: Aspects of Evaluation for Supervision. Dates: May 16 through 20; repeated October 24 through 28, and March 13 through 17, 1961. (2) Director: Miss Theresa Phelps, assistant professor of nursing. Sub-

Complete or Partial Privacy as Desired

for Semi-Private Rooms and Wards

with the new Hill-Rom A.E. (aluminum extruded) screening

The illustration shows how the new Hill-Rom A.E. Screening enables the nurse to give the patient complete or partial privacy as desired. Here the curtain has been closed merely enough to shield the patient being treated from the patient in the adjoining bed. When complete privacy is desired, the curtain is entirely closed, providing absolute privacy for each patient.

The smooth, quiet operation of Hill-Rom A.E. Screening is easy on patients and nurses alike. The lifetime nylon slides glide silently along the sturdy, extruded track. No jerking, no coaxing, no twitching, no tugging.

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3 DIFFERENT TYPES OF INSTALLATION

The new Hill-Rom A.E. Screening can be installed in three different ways:

1. Surface mounted (ceiling type)
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Any size or shape of room—in any type of building—old or new—can be completely screened.

ject: Methods of Instruction for Teachers in Schools of Nursing. Dates: September 12 through 23; repeated January 16 through 27, 1961, and May 8 through 17, 1961.

To be eligible for federal traineeships for these courses, nurse candidates must be United States citizens, graduates of state-approved basic schools of nursing, licensed as professional nurses in a state or United States possession, and currently employed or committed to a position in administration, supervision, or teaching of nursing.

Nurses wishing to take these short-term courses should direct further inquiry to the program director of the sponsoring agency. ■

ACHA Issues New Directory; 3800 Biographies Included

The *1960 Directory*, the first comprehensive biographical dictionary of its entire membership to be compiled since 1948, has been published by the American College of Hospital Administrators. The directory contains detailed biographical data about all fellows, honorary fellows, members and nominees of the college.

Three major sections comprise the directory: An introduction containing descriptive information on the college, its membership and program; the major section of biographical listings, and the final section containing a classified regional index.

The *1960 Directory*, which contains more than 3800 biographical listings, costs $15, and is available from ACHA headquarters, 840 N. Lake Shore Drive, Chicago 11. ■

Groups Elect Officers

Georgia Hospital Association: president, George E. Linney, administrator, Griffin-Spalding County Hospital, Griffin; president-elect, Arthur T. Stewart Jr., administrator, Minnie G. Boswell Memorial Hospital, Greensboro; secretary-treasurer, Thomas B. Wolfe Jr., administrator, Polk General Hospital, Cedartown.

Kentucky Hospital Association: president, Malcolm Black, administrator, District 6 Tuberculosis Hospital, Glasgow; president-elect, Homer D. Coggins, administrator, Central Baptist Hospital, Lexington; treasurer, Edward W. Horgen, administrator King's Daughters' Hospital, Ashland.

Hospital Council of the National Capital Area: president, Henry Grattan Doyle, Ph.D., trustee, Washington (D.C.) Hospital Center; first vice president, Fred A. McNamara, trustee, Columbia Hospital for Women, Washington, D.C.; second vice president, C. Carroll Morgan, president, Suburban Hospital, Bethesda, Md.; secretary, Victor F. Ludewig, administrator, George Washington University Hospital, Washington, D.C.; treasurer, Rudolph Kauffmann II, president, Children's Hospital, Washington, D.C.

Wisconsin Hospital Association: presiden, Msgr. Edmund J. Goebel, superintendent of schools and director of hospitals, Milwaukee Catholic Archdiocese; president-elect, Nels E. Hanshus, administrator, Luther Hospital, Eau Claire; first vice president, Sister Mary David, administrator, St. Agnes Hospital, Fond du Lac; second vice president, John R. Temte, administrator, Memorial Hospital, Neillsville; treasurer, Robert M. Jones, administrator, Waukesha Memorial Hospital.

Puerto Rico Hospital Administrators Association: president, Arturo A. Plard, administrator, Presbyterian Hospital, Santurce; president-elect, Luis Martín Jiménez, administrator, Clinica Mimiya, Santurce; vice president, Maggie Cabranes, assistant director, Medical Care Survey, Department of Health, Santurce; secretary, Ramon A. Rivera, administrative assistant, Division of Hospitals, Department of Health, Santurce; treasurer, José Luis Meléndez, assistant director, Medical Center Project, Department of Health, Santurce. ■

State Association Presidents

ALABAMA

DONALD G. HARMS
Administrator
DeKalb County
General Hospital
Fort Payne

ILLINOIS

DELBERT L. PRICE
Administrator
Children's Memorial Hospital
Chicago

MICHIGAN

A. KENT SCHAFER
Administrator
James Decker Munson
Hospital
Traverse City

NEBRASKA

PAUL FINNMAN
Administrator
Memorial Hospital
North Platte

NORTH CAROLINA

EDWARD R. FRYE
Administrator
Good Samaritan Hospital
Charlotte

VIRGINIA

WILLIAM R. REID
Administrator
Jefferson Hospital
Roanoke

CURRENT LISTINGS OF NEW ASSOCIATION MEMBERS

NEW INSTITUTIONAL MEMBERS

ALABAMA

South Baldwin Hospital, Foley.

CALIFORNIA
Oceanside Hospital, Inc., Oceanside.
DISTRICT OF COLUMBIA
Program in Hospital Administration, The George Washington University, Washington.
ILLINOIS
Illinois State Psychiatric Institute, Chicago.
MINNESOTA
Granite Falls Municipal Hospital, Granite Falls.
MONTANA
Silver Bow General Hospital, Butte.
NEW YORK
Medical International Cooperation Organization, Inc., New York.
OHIO
Charles F. Kettering Memorial Hospital, Dayton.
OKLAHOMA
Memorial Hospital Company, Collinsville.
PENNSYLVANIA
Holy Redeemer Hospital, Meadowbrook.
TENNESSEE
Rhea County Hospital, Dayton.
TEXAS
Gipson Hospital, Three Rivers.
BELGIUM
Institut Jules Bordet—Universite Libre de Bruxelles, Brussels.

HOSPITAL AUXILIARIES

Corning (Calif.) Memorial Hospital Womens Auxiliary.
Wheeler Hospital Auxiliary—Gilroy, Calif.
Women's Auxiliary of the French Hospital—San Francisco.
Auxiliary of the Community Memorial Hospital, Inc.—Marysville, Kans.
Missouri Baptist Hospital Woman's Association—St. Louis.
Elizabeth A. Horton Hospital Auxiliary—Middletown, N.Y.
St. Charles Hospital Women's Auxiliaries —Port Jefferson, N.Y.
Junior Auxiliary to Riverside Hospital—Toledo.
Salem (Ore.) Memorial Hospital Auxiliary.
Auxiliary of Brownsville (Pa.) General Hospital.
Madison (S. Dak.) Community Hospital Auxiliary.
Baptist Memorials Geriatric Hospital Auxiliary—San Angelo, Tex.
Women's Auxiliary, Charles Town General Hospital—Ranson, W. Va.
Auxiliary of St. Elizabeth Hospital—Appleton, Wis.

Hospital association meetings

(Continued from page 6)

(Federal Building and Clift Hotel)
27 ***American Association of Hospital Consultants,*** San Francisco (Fairmont Hotel)
27-31 ***American College of Hospital Administrators,*** San Francisco (Jack Tar Hotel)
29-Sept. 1 ***American Association of Nurse Anesthetists,*** San Francisco (Civic Auditorium and Sheraton-Palace)

SEPTEMBER

12-13 Montana Hospital Association, Missoula (Florence Hotel)
12-16 **Nursing Service Administration,** Buffalo (Lafayette Hotel)
18-20 Colorado Hospital Association, Estes Park (Stanley Hotel)
22-24 West Virginia Hospital Association, White Sulphur Springs
24-27 ***College of American Pathologists,*** Chicago (Palmer House)
26-30 **Central Service Administration,** Chicago (AHA Headquarters)
27-30 ***American Society of Clinical Pathologists,*** Chicago (Palmer House)

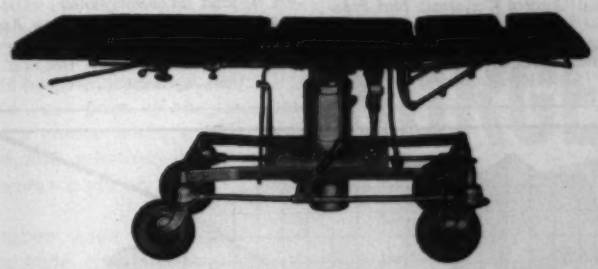
OCTOBER

2-7 ***American Society of Anesthesiologists,*** New York City (Statler Hotel)
4 Hospital Association of Rhode Island, Providence (Sheraton-Biltmore Hotel)
5-7 **Hospital Laundry Management and**

EACH A "MUST" and each a

RELIANCE

Model 25-AA
ALL-PURPOSE STRETCHER



FOR: Use in Emergency Rooms
X-ray therapy treatment
Minor surgery
Examination

Features:
11 inch hydraulic height adjustment
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Conductive Rubber Tires are standard
Conductive Cover optional at no additional cost

Model 475-FB Foot-Operated Hydraulic Chair for EENT and OUT-PATIENT Departments

Superbly built; maintenance-free; reasonably priced. Easy to raise—space-saving, will accommodate all patients.

- Single lever raises, lowers, and locks revolving action
- Fully adjustable head rest, extremely comfortable
- Chair back reclines to any desired angle
- Base column in choice of colors, other parts chrome-plated
- Matching or contrasting genuine leather upholstery
- Chair available as shown (or Model 475-F without foot rest)

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Maximum comfort and convenience. Seat and back upholstered with conductive cover over thick rubber pad. Instantly adjustable from 21" to 31". Seat revolves freely. Base in brilliant chrome. Has conductive casters. Back rest may be adjusted for greater comfort.

No. 406—upholstered in GENUINE LEATHER, regular casters.
No. 400—without back rest, regular casters.

See these and other models at your authorized dealer, or write for brochures.

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Operation, Chicago (AHA Headquarters)

6-8 ***American Association of Medical Clinics,*** New Orleans (Roosevelt Hotel)

7-17 ***National Federation of Licensed Practical Nurses*** Albuquerque, N. Mex. (Hilton Hotel)

10-13 ***American Association of Medical Record Librarians,*** Seattle (Olympic Hotel)

10-13 **Evening and Night Nursing Service Administration,** Pittsburgh (Pick-Roosevelt Hotel)

10-14 ***American College of Surgeons,*** 46th Annual Clinical Congress, San Francisco

12-13 Indiana Hospital Association

12-14 **Hospital Pharmacy (Specialized),** Chicago (AHA Headquarters)

12-14 Maryland-District of Columbia-Delaware Hospital Association, Washington (Shoreham Hotel)

12-14 Saskatchewan Hospital Association, Saskatoon (Bessborough Hotel)

17-18 Idaho Hospital Association, Boise (Elks Lodge)

17-18 Oregon Hospital Association, Gearhart (Gearhart Hotel)

17-20 ***American Dental Association,*** Los Angeles (Statler-Hilton Hotel)

17-20 **Management Development,** Chicago (AHA Headquarters)

18-21 ***American Dietetic Association,*** Cleveland (Sheraton Hotel)

18-21 ***American Nursing Home Association,*** Washington, D.C. (Mayflower Hotel)

19-20 Washington State Hospital Association, Spokane (Davenport Hotel)

20-21 Nebraska Hospital Association, Omaha (Sheraton-Fontenelle)

24-26 **Directors of Hospital Volunteers (Basic)** Cleveland (Statler Hotel)

24-26 Ontario Hospital Association, Toronto (Royal York Hotel)

24-28 California Hospital Association, Santa Barbara (Miramar and Biltmore Hotels)

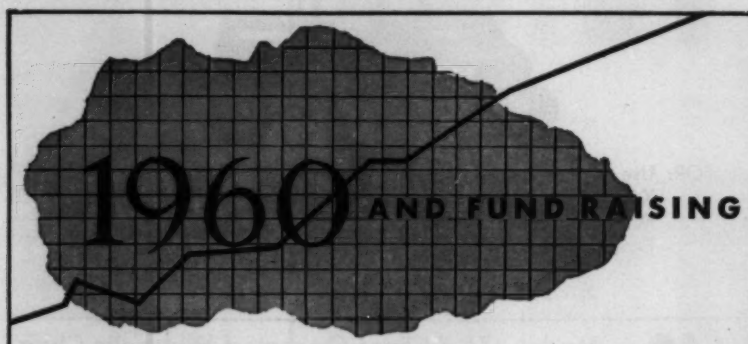
24-28 **Medical Social Work in Hospitals,** Kansas City (Bellerive Hotel)

25-26 South Dakota Hospital Association, Mitchell (Masonic Temple)

25-27 Associated Hospitals of Manitoba, Winnipeg (Royal Alexandra Hotel)

31-Nov. 3 **Staffing Departments of Nursing** Chicago (Headquarters)

31-Nov. 4 ***American Public Health Association,*** San Francisco (Civic Center)



FROM the vantage point of 40 years of successful experience, we believe that 1960 offers the most favorable climate that has ever prevailed for hospital fund raising.

The nation's economic strength and the advance of philanthropy to a new high suggest action by hospitals considering new additions or the renovation of existing facilities.

Increasingly, hospitals turn to Tamblyn and Brown, Inc. for: 1) study and counsel concerning the justification and success potential of a fund campaign, and 2) organization and direction of an individualized campaign that builds good will while attaining gratifying results.

Additional information that may help your hospital will be given gladly upon request, without cost or obligation.

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CHARTER MEMBER, AMERICAN ASSOCIATION OF FUND-RAISING COUNSEL

Editorial notes

(Continued from page 41)

treatment errors are on the increase. In one state in which the reporting of accidents and "incidents" involving patient care in hospitals is particularly comprehensive and reliable, statistics for 1959 showed a 5 per cent increase in the number of medication errors over 1958. Such errors constituted 18 per cent of all reported incidents which might lead to claims and suits. Medication and treatment errors may be catastrophic, and from a practical standpoint possibly there may be no valid defense in court when such errors result in injury to patients.

For these reasons, the two-part article on medication errors by Miriam A. Safren and Alphonse Chapanis, Ph.D., in this issue and the preceding issue of HOSPITALS, J.A.H.A., is timely and important. As usually happens, a deep and penetrating study of a small series of cases has yielded much more valuable information than a superficial analysis of a large series. The causes of medication and treatment errors and the recommendations for prevention of such errors outlined by Safren and Chapanis in Part II of their article (page 53) deserve careful study by all who have a responsibility for the care of patients in hospitals and they merit a place of priority on the agenda of medicolegal education committees of individual hospitals.—AUGUST H. GROESCHEL, M.D., *associate director for professional services, New York Hospital, New York City.*

Washington Report

(Continued from page 112)

salary of VA hospital managers and at $16,250 that of directors of professional services. The committee noted that these salary rates now vary and are often below those received by individual physicians serving in capacities subordinate to VA hospital managers.

Another bill is designed to increase by 5 to 10 per cent the patient turnover in VA hospitals by shortening hospital stays through the addition of outpatient services for nonservice-connected cases before or after hospitalization. Outpatient care for service-connected cases is already provided.

The VA committee declared that the advancing age of veterans makes it "obvious that the pressures upon the Veterans Administration medical system are going to mount almost daily."

In a vote on fiscal 1961 appropriations for the VA, the full House of Representatives restored VA's budget for modernization and rehabilitation of its hospital plant to the $75 million originally requested. The House Appropriations Committee had recommended a cut to $39.1 million.

The full House also voted approval of VA's 1961 budget request of $817 million for inpatient care, an increase of almost $25 million over 1960. It voted $86.4 million for outpatient care, an increase of $2.6 million from 1960.

Administrative research and improvements

(Continued from page 45)

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How to organize a department head manual

(Continued from page 60)

of the policy is to be identified, such as the personnel director, the signature should consist of the administrator's name followed by a diagonal and the originator's initials (John A. Smith/AJW).

Date each page so the user can tell at a glance when a policy was issued and whether it supersedes a previous issue on the same subject.

Number each page with the proper code (if a numeral system is used), so that its place in the manual can easily be determined.

In addition to the code number, each page should be numbered to indicate how many other pages are included on a given subject and the relation of the new page to the other pages.

Those receiving the policy should be indicated in the format. Department heads who are not involved in a given policy need not be concerned with its details.

2. Reasons for the manual, how new additions and changes will be made, and an outline of the manual's organization should be included on its front page.

3. One person or group should be responsible for keeping the manuals up to date by writing new policies, determining where in the manual a new page belongs, and issuing new pages.

4. A loose-leaf or prong-fastener binder should be used so the manual can be conveniently updated.

5. The first page of each section and subsection should contain an outline of its contents.

6. Each manual should be issued to a specific department head. He will be responsible for its safekeeping and for keeping it current as new materials are issued.

With the increased authority of knowledge, the department head can be held responsible to a greater degree for the activities of his department. The administrator can use the department head manual to help his department heads grow

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and thus better equip them for communicating effectively. This is one more element which will enable the hospital to improve its service to its patients. ■

County-wide alert unites community disaster plans

(Continued from page 58)

factory had agreed to have the mock disaster simulated at their plant. When the fire and explosion happened at 1:30, the regular fire drill procedures at the plant would go into operation and civil defense headquarters would be notified. This would throw the civil defense procedures into effect.

The plant would be completely evacuated except for the 41 casualties. To be sure that all accidents were covered, the cards would be marked before the alert and casualties would be tagged when the alert began. They were to be located all over the plant. When the medical officer and aides arrived, they could identify injuries from the tags. The plant was to stay completely evacuated until all casualties had been given emergency first aid treatment and dispatched to the two hospitals.

The fire department was actually to reel out hose from the hydrants to the plant. Since hydrants were across the street from the plant, all traffic on the two heavily traveled federal highways in front of the plant was to be stopped while the casualties were being removed.

MOVIES RECORD THE ALERT

Movies were to be made of various aspects of the operation; this would cost approximately $100. Two critiques would be held to evaluate the alert and to correct obvious mistakes; the first would be held immediately after the alert and the second approximately two weeks later. Since a visual record would help in conducting the second critique, the two hospitals, the city and the county governments agreed to underwrite the movie film for $25 each. The civil defense director was to arrange for these films to be taken at the scene of the disaster and at the hospitals.

The two hospitals requested additional volunteer and auxiliary personnel to act as stretcher bearers and traffic control officers.

The civil defense medical officer stated that three ambulances and a school bus would bring casualties to the tuberculosis hospital. We requested that additional vehicles be used to create more traffic control problems when the casualties arrived.

All those present at the meeting felt that with a few exceptions, all needed organizing and planning had been done for the test.

HOSPITAL PREPARATIONS

In the following week, the hospitals perfected their internal arrangements. Each employee and auxiliary worker was given a pass permitting entrance to the hospital grounds in case of emergency. This was necessary because the police had instructions that sightseers and curiosity seekers were not to be admitted to the grounds.

A special situation was created at the tuberculosis hospital, because Thursday afternoon is one of two weekly visiting days. Since hospital patients come from 23 counties, many visitors drive a great distance. It would not have been good public relations to deny them entrance to the grounds should they arrive during the alert.

A large parking lot behind the hospital, to be utilized in no way during the alert, solved the problem. All visitors, when stopped by the police at the gate, were to be given pink passes. Scouts and hospital personnel directing traffic would send cars with these passes to the parking lot and request that occupants remain there until the alert was terminated.

The hospital switchboard operators prepared lists of all employees and their telephone numbers. When advised of the alert each department head was to call the administrator immediately, giving him the names of all off-duty employees. The administrator would inform the switchboard operator so that she could call off-duty personnel.

INTERNAL HOSPITAL PLANS

The internal plan of the tuberculosis hospital was:

1. Disaster headquarters would be in the administrator's office, adjacent to the switchboard and public address system. After the disas-

ter report, the administrator would proceed to his office to direct hospital operations. The assistant administrator would proceed to the first floor to coordinate operations and assist in receiving and processing casualties.

2. Traffic control would be regulated by one man from the laundry and the Boy and Girl Scouts. Another man in the laundry department and three men in engineering, with the male Red Cross aides, would report to the front of the building in the clinic area—this would become the admitting area—to act as stretcher bearers.

3. The admitting area would be supervised by the assistant hospital director; the director of nurses and two aides or practical nurses would assist him. Two office girls in the area would get information for the identification cards from the casualties. Cards would be filled out if there was time and the patient was not in critical condition.

4. Triage area No. 1 would be in charge of the medical director and assistant director of nurses and triage area No. 2 would be in charge of the surgical team. The housekeeping women were responsible for rolling the stretchers from admitting area to triage areas. Male housekeeping personnel would assist in lifting patients from stretchers to examining tables and operating tables in triage areas. Prior to the arrival of casualties, the housekeeping department would make cots, blankets, and pillows available to receive patients.

5. Wheel chairs and wheel stretchers would be taken by the nursing department to the admitting area; the department would also provide graduate nurses and aide coverage in all three areas during the entire alert.

6. Emergency supplies would be dispensed by the storekeeper with two assistants, one of whom was to be in the storekeeper's office at all times to answer the phone. They were to store all valuables collected from casualties in either the admitting area or the triage areas.

7. All telephone calls into the hospital would go directly to the administrator; outgoing requests for materials, supplies, or personnel were to be made to the administrator. He would instruct the switchboard operator on what calls to place.

8. The laboratory and x-ray personnel would remain at their stations to perform their specific duties as required.

9. Dietary personnel were not to be utilized because they would be needed to provide additional nourishment for the greater patient load in case of a real emergency.

The tuberculosis hospital is always full; casualties would therefore be located in corridors and unused areas unless the actual disaster were so great that additional beds were required. In this case, tuberculosis patients that could be discharged would be sent home to make available additional emergency beds.*

On the day of the disaster, there was no unusual activity of any kind. The administrator had a

*A detailed copy of this disaster plan may be requested from State Tuberculosis Hospital, Paris, Ky.

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radio in his office tuned to the local radio station.

At 1:30 promptly, a program of mountain music was interrupted by the tape recording announcing the practice alert. Then the announcer instructed all hospital employees and all auxiliary members to report to their respective hospitals immediately. The recording and instructions for personnel were repeated three times at five minute intervals.

Timing of our alert was as follows:

1. *1:38 . . . The civil defense director* advised the switchboard operator of a disaster at Hansley Mills with casualties expected at the hospital very soon. The operator immediately advised the administrator, who announced over the public address system that a disaster alert was in effect. This signaled the hospital machinery into operation.

2. *1:41 . . . Within three minutes,* all department heads had reported to the administrator the names of off-duty employees, which were turned over to the switchboard operator. After notifying the administrator of the alert, the operator phoned the auxiliary president, asking her to start contacting her members.

3. *1:37 . . . Police arrived* at the entrance of the hospital and set up two-way radio communication.

4. *1:39 . . . Girl Scouts arrived* with their leader.

5. *1:40 . . . The first carload* of Red Cross male aides and first members of the auxiliary got to the hospital.

6. *1:41 . . . Boy Scouts arrived.* Sirens were heard in the distance.

7. *1:42 . . . First ambulance* bearing casualties arrived. The surgical team had not reported as yet.

8. *1:50 . . . Every employee* of the hospital was on duty. We admit that this record could not have been maintained for an unplanned alert. Some employees and volunteer personnel had no telephones, but, knowing about the alert, had reported to the hospital automatically at 1:30.

9. *1:52 . . . Three station wagons* with large Red Cross markings on the hoods arrived with additional casualties.

10. *2:00 . . . Six additional station wagons* and a school bus loaded with casualties had arrived.

The assistant administrator informed the administrator that the surgical team had not arrived. The civil defense director was immediately told of this. A few minutes later the administrator was advised by the medical director in triage area No. 1 that the surgical team had not arrived. He then received a third message from triage area No. 2 stating that there were three critical casualties in that area with no physician attending.

The administrator said he would attempt to get some members of the team to the hospital as soon as possible. In the meantime, the medical director was requested to leave the less serious cases in charge of the nurse in triage area No. 1 and proceed to the serious cases in triage area No. 2.

The administrator again advised the civil defense director that if

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additional physicians were not received immediately some casualties would probably expire. The director had learned from the civil defense medical officer that one team member was out of town, and the other two members were in emergency surgery in the general hospital. It was impossible to send additional physicians to the tuberculosis hospital.

The various parties concerned were advised of this fact by the administrator. Appropriate arrangements were made so that the more serious cases received medical attention first, while the less serious, such as burns, were given first aid by registered nurses. After processing the patients through the first aid admitting area, the assistant medical director reported back to triage area No. 1 to complete processing those patients.

At 2:15, the civil defense office advised that there would be no more casualties. There had been some confusion in the allocation of casualties; instead of the planned 21 casualties, 30 casualties came to the tuberculosis hospital and only 11 to the general hospital. Although this caused considerable congestion in the admitting area, it proved invaluable for giving the personnel experience.

NEEDED: ONE DENTIST

The medical director told the administrator that he required a dentist for a severe jaw fracture case. This had not been in the plan. However, it was good experience to see the result when the administrator called the civil defense director, requesting a dentist immediately. Within 10 minutes a police cruiser arrived with the dentist.

After the casualties had been given first aid and treatment, they were placed on stretchers, cots, or chairs in the corridors. At 2:45, the hospital director announced that all casualties had been processed. The hospital administrator called the civil defense director for permission to give the all clear. The announcement was made over the public address system that the emergency alert was terminated and employees should return to their regular duties.

After the bandages, splints, and catsup were removed, the hospital served refreshments to the volunteers, employees, and casualties, and a school bus transported the plant workers to the factory.

MEETING NO. 4: ANALYSIS

Immediately after the alert, key personnel gathered in the administrator's office to discuss what had happened. We decided that the dental society should have been included in the planning. The reporting system on names and condition of casualties to the switchboard and administrator was also found to be faulty. The bottom parts of the tags were supposed to be torn off after information had been recorded on them concerning each casualty. These cards were to be brought to the administrator's office so that information about the patients could be given to the press, friends, and relatives.

These torn-off stubs were everywhere but in the administrator's office; they did not become available to him until after the alert

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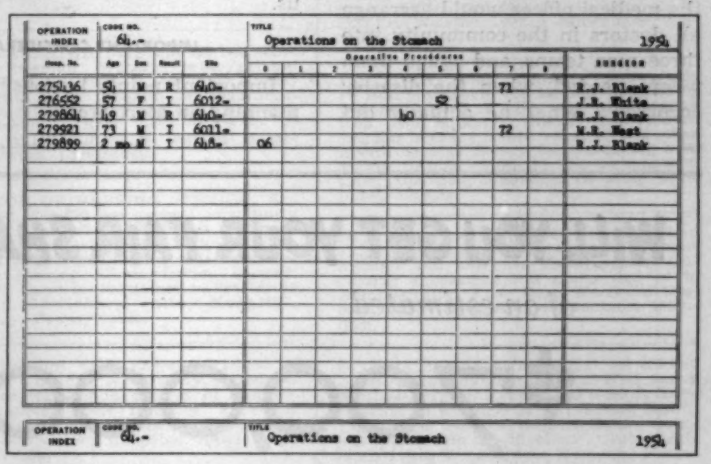
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Hosp. No.	Age	Sex	Result	Site	Operative Procedures 0	1	2	3	4	5	6	7	8	SURGEON
275536	54	M	R	640-								71		R. J. Black
276552	57	F	T	6012-						52				J. R. White
279864	49	M	R	640-					40					R. J. Black
279921	73	M	T	6011-								72		M. R. West
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was terminated. Finally, it was noted that civil defense authorities did not notify the hospitals of the approximate number of casualties to be expected. These problems were all mechanical in nature and could be easily corrected.

TWO CRITICAL PROBLEMS

The two most critical problems encountered during the disaster alert were the shortage of physicians, and the congestion at the admitting area when the bulk of the casualties arrived in a very short period of time.

More satisfactory arrangements were needed for getting additional physicians in case of a real emergency. It would have been impossible for our two resident physicians to have processed the 30 casualties that came through our admitting area as rapidly as they should have been processed.

Previously we had decided that the medical officer would "arrange all doctors in the community into three-man teams, and assign them where needed, when the disaster occurred". What he actually did was assign them to one of the two hospitals long before the alert was called.

The only way to be sure that each hospital has a sufficient number of physicians to cope with the increased patient load is to assign just one team to each hospital beforehand. All other teams should remain unassigned until the medical officer has evaluated the type of disaster and types and number of casualties and the number of physicians available.

Congestion in the admitting area can best be solved by first, having this room as large as possible (a minimum of 1200 sq. ft.) and second, having the first stop that the casualty makes be as far from the entrance door as possible. Then, as the casualties accumulate they will have the entire admitting area room to spread out in rather than completely obstructing the front door, which is what happened to us.

IMPORTANT CONSIDERATIONS

Important points to consider in planning an alert are:

1. Give yourself a reasonable length of time to get ready—not so long that interest will lag but not so short that plans can't be thought out and deliberately laid.
2. Schedule the dates for all your meetings (not too many) at the beginning of your planning.
3. Agree, and distribute in writing, what is to be accomplished at each meeting.
4. Be sure that those who are to participate in the alert are kept well informed by the planning committee.
5. Be diplomatic, particularly in the initial stage, and do not step on the toes of civil defense. Planning an alert is their responsibility. Yours as hospital administrator commences when the first casualty enters your admitting area.

We feel that we profited from our disaster alert. It should probably be repeated at least once every year or two, so that we all continue to be familiar with our duties and responsibilities, and so new employees and volunteers can be initially trained in case of real disaster. ■

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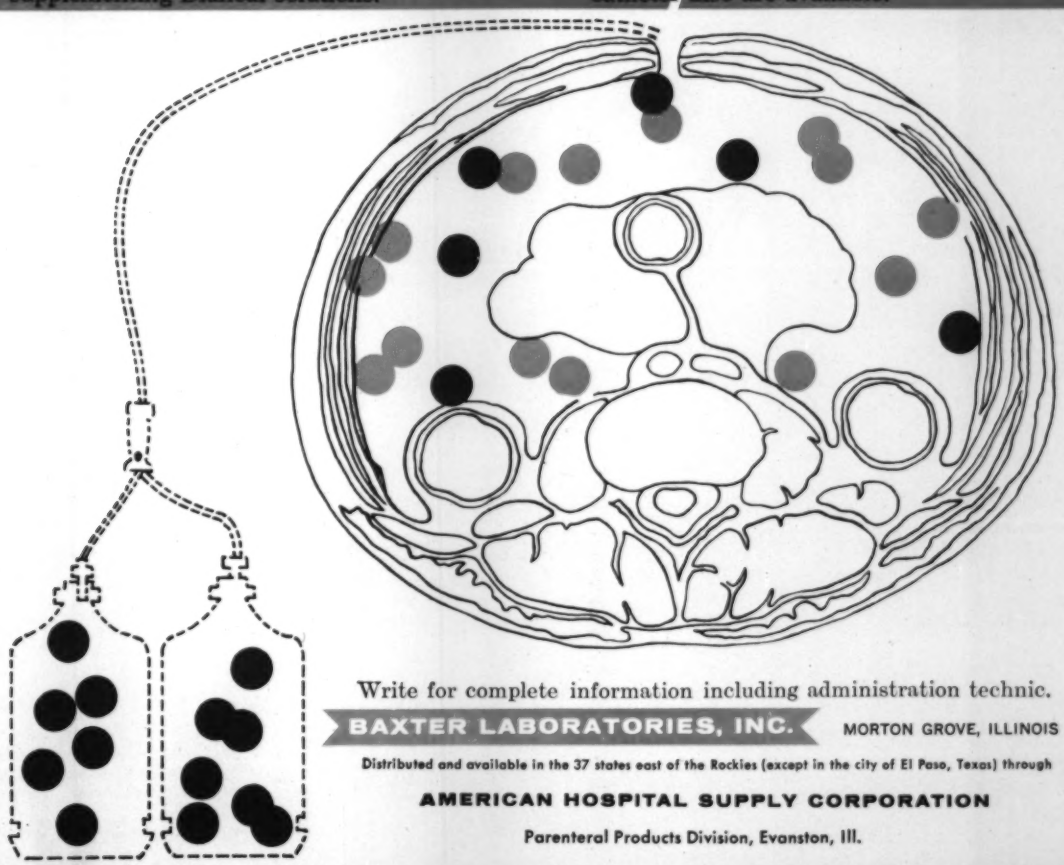

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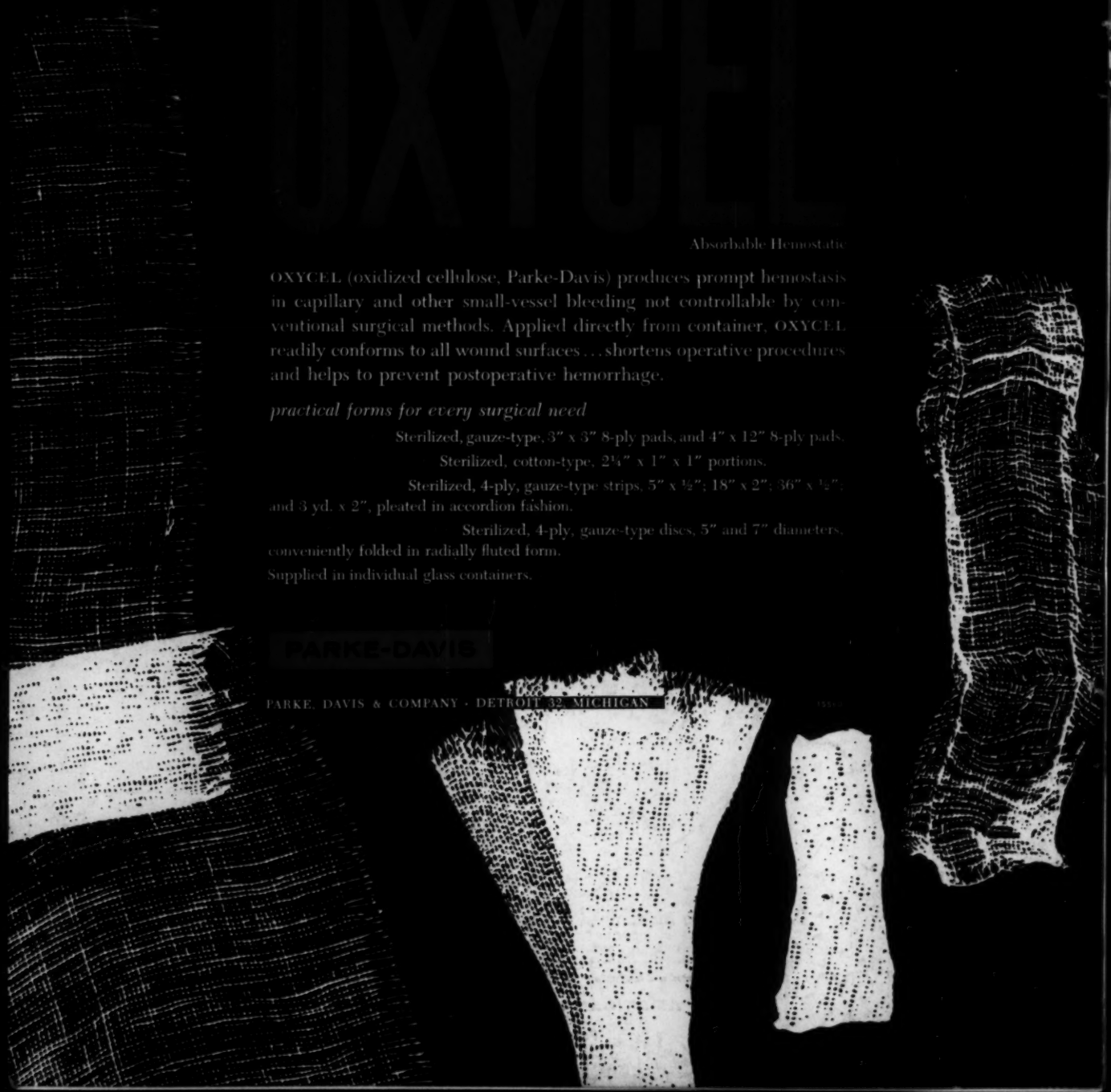
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